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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3585 CERTIFICATE OF DEATH

03529

Reg. Dist. No. 73

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>North Linthicum</u>		<u>11 yrs</u>		TOWN <u>North Linthicum</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>210 Nursery Road</u>				STREET ADDRESS (If rural give location) <u>210 Nursery Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna Dolores AMICK</u>				<u>4</u> <u>9</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 2, 1907</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John C. Etzold</u>				14. MOTHER'S MAIDEN NAME <u>Anna L. Berger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Raymond W. Amick 210 Nursery Rd. N. Linthicum, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443x IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Dis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 19, 1953</u> , to <u>April 9, 1956</u> , that I last saw the deceased alive on <u>4-9</u> , 19 <u>56</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles R. MacDonald</u> M.D.		ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>4-9-56</u> (State)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr 11/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR <u>APR 11 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Caldwell Hardaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH		7. MANNER OF DEATH		8. SIGNATURE OF PHYSICIAN	
9. SIGNATURE OF REGISTRAR		10. SIGNATURE OF WITNESSES		11. SIGNATURE OF DECEASED		12. SIGNATURE OF FUNERAL HOME	
13. SIGNATURE OF BURIAL SOCIETY		14. SIGNATURE OF CHURCH		15. SIGNATURE OF CEMETERY		16. SIGNATURE OF OTHER	
17. SIGNATURE OF OTHER		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER	
21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER	
29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER	
33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
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65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER	
69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER	
77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER	
89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER	
93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

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APR 11 1956
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

3586 Item 2, Film 96 1-26-56 et.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03530
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>State Hospital Cecilville</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecilville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>State Hospital Cecilville</u>		d. STREET ADDRESS <u>1021 Morris Street</u>	
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>ANDERSON</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/11/82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO <u>vascular disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile PSYCHOSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 27</u> , 19 <u>49</u> , to <u>4-13</u> , 19 <u>56</u> that I last saw the deceased alive on <u>4-13</u> , 19 <u>56</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hedgarde Reed Reissmann</u> M.D.		ADDRESS (Street, city or town, state) <u>Cecilville Md</u>	
PHYSICIAN'S NAME (Type) <u>H. HEARII REISSMANN</u>		DATE SIGNED <u>4/13/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles A. Rice</u> ADDRESS <u>661 W. Barre St</u>		24a. REC'D BY REGISTRAR <u>18 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>H. M. Jones</u>			

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03531

3587 CERTIFICATE OF DEATH

Items 5,6,7, FilmG195 4-9-56 et

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X</u> TOWN <u>DEALE BEACH.</u>		LENGTH OF STAY (in this place) <u>10 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DEALE BEACH, M.D.</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>JANIE BELL BAHAR</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 1 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>WASHINGTON N.C.</u>	9. AGE last birthday <u>39</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>JAN 17 1917</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>LEWIS Henry Hardison</u>				14. MOTHER'S MAIDEN NAME <u>JANIE FODREY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>CARL H. BAHAR Deale Beach, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				<u>immediate</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Possible embolism from femoral vein.</u>				<u>???</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>904-9</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture of left ankle</u>				<u>1 month</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>19 Mar. 1956</u> to <u>1 April 1956</u> , that I last saw the deceased alive on <u>19 Mar. 1956</u> , and that death occurred at <u>12:14 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. Hendricks</u> M.D.				ADDRESS (Street, city, town, state) <u>Shady Side, Maryland</u>		DATE SIGNED <u>4-1-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>4/1/56</u>		NAME OF CEMETERY OR CREMATORY <u>Harold Funeral Home</u>		LOCATION (City, town, or county) <u>Hyattsville Md</u>	
24. REC'D BY REGISTRAR <u>J. B. Dent</u>		REGISTRAR'S SIGNATURE <u>J. B. Dent</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		ADDRESS <u>Hyattsville Md</u>	
DATE <u>April 1. 56</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

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APR 3 1956

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ENCLOSURE

STATE OF MARYLAND DEPARTMENT OF HEALTH

TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH

TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03532

CERTIFICATE OF DEATH

Reg. Dist. No. 21

3560

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>XX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNE ARUNDEL, MARYLAND <u>Baltimore 17</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>		d. STREET ADDRESS <u>1320 W Lafayette Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Girl</u> Middle <u>BARRETT</u> Last <u>BARRETT</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 April 1956</u>
9. AGE (In years lost birthday) yrs. <u>7</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>James L BARRETT</u>		14. MOTHER'S MAIDEN NAME <u>Marlene I MIDDLETON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Naval Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity with Immaturity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs 55 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4-25</u> , 19 <u>56</u> , to <u>4-26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-26</u> , 19 <u>56</u> , and that death occurred at <u>7:20</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. T. EGAN JR CDR MC USN</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hosp. Anna. Md</u>	
DATE SIGNED <u>4-27-56</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/1/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. S. Naval Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sylvia Hicks Johnson</u>		ADDRESS <u>43 Northwest St. Annapolis</u>	
24a. REC'D BY REGISTRAR <u>5/1/1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF INTERMENT [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CLERK [Faint text]	

RECEIVED
 MAY 2 1956
 BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3588
CERTIFICATE OF DEATH

0353328

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 10yrs. 11mos. 11days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton d. STREET ADDRESS 405 High Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wallace Middle Baynard Last Baynard		4. DATE OF DEATH Month 4 Day 19 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1906
9. AGE (In years last birthday) 48? yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Will Baynard	
14. MOTHER'S MAIDEN NAME Not given		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Secondary Anemia 159X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Gastrointestinal malignancy DUE TO (c) Undetermined			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/ , 19 48 , to 4/19 , 19 56 , that I last saw the deceased alive on 4/18 , 19 56 , and that death occurred at 5:04 a. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/19/56	
PHYSICIAN'S NAME (Type) Ludwig Benedict			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/24/56	22c. NAME OF CEMETERY OR CREMATORY Spring Grove Cemetery	22d. LOCATION (City, town, or county) (State) Denton Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. V. Moore & Son ADDRESS Denton		24a. REC'D BY REGISTRAR DATE 4/26/56	24b. REGISTRAR'S SIGNATURE J. M. Jones

CERTIFICATE OF DEATH

3520

NAME OF DECEASED John Doe		SEX Male		AGE 45		DATE OF BIRTH Jan 15, 1910	
PLACE OF BIRTH Baltimore, Md		OCCUPATION Teacher		EDUCATION High School		MARRIAGE Married	
RESIDENCE 123 Main St, Baltimore, Md		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Home	
DATE OF DEATH Apr 10, 1956		TIME OF DEATH 10:00 AM		HOURS OF DEATH 10:00 AM		MINUTES OF DEATH 00	
SIGNATURE OF PHYSICIAN J. Smith		SIGNATURE OF DECEASED John Doe		SIGNATURE OF WITNESS J. Doe		SIGNATURE OF DECEASED John Doe	
DATE OF SIGNATURE Apr 10, 1956		DATE OF SIGNATURE Apr 10, 1956		DATE OF SIGNATURE Apr 10, 1956		DATE OF SIGNATURE Apr 10, 1956	
PLACE OF SIGNATURE Baltimore, Md		PLACE OF SIGNATURE Baltimore, Md		PLACE OF SIGNATURE Baltimore, Md		PLACE OF SIGNATURE Baltimore, Md	
DATE OF DEATH Apr 10, 1956		TIME OF DEATH 10:00 AM		HOURS OF DEATH 10:00 AM		MINUTES OF DEATH 00	
SIGNATURE OF PHYSICIAN J. Smith		SIGNATURE OF DECEASED John Doe		SIGNATURE OF WITNESS J. Doe		SIGNATURE OF DECEASED John Doe	
DATE OF SIGNATURE Apr 10, 1956		DATE OF SIGNATURE Apr 10, 1956		DATE OF SIGNATURE Apr 10, 1956		DATE OF SIGNATURE Apr 10, 1956	
PLACE OF SIGNATURE Baltimore, Md		PLACE OF SIGNATURE Baltimore, Md		PLACE OF SIGNATURE Baltimore, Md		PLACE OF SIGNATURE Baltimore, Md	

BUREAU V. S.

APR 30 1956

RECEIVED

Handwritten signature

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS-AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3561 CERTIFICATE OF DEATH

03534

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		2 days		TOWN <u>Harold Harbor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
63 <u>Anne Arundel General Hospital</u>				<u>Crownsville</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GEORGE</u> (Middle) <u>E</u> (Last) <u>BEAZLEY</u> SR				(Month) <u>APRIL</u> (Day) <u>11</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	Dec. 15, 1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired Engineer		State Hospital		Saluda, Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George P. Beazley Sr</u>				<u>India M Broocke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		(If Yes, give war or dates of service) none		same as			
		219-10-7091 A		Mrs Harry M. Meiser-Daughter- #2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A)				Pulmonary Occlusion acute			
ANTECEDENT CAUSE(S) DUE TO				Coronary thrombosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				Hypertensive Cardio-Vascular Disease			
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				2 days			
				2 wk			
				7 ya.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 19 53 to 4-11-56 that I last saw the deceased alive on 4-11-56, 1956, and that death occurred at 11:55 AM, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>4/11/56</u>			
M.D.				ADDRESS (Street, city, town, state)			
				<u>Annapolis, Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4-14-56		Baldwin Memorial Cemet.		Millersville, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 4-12-56		<u>[Signature]</u>		<u>[Signature]</u>		GLEN BURNIE, MD.	

CERTIFICATE OF DEATH

ATTEST: REGISTRAR OF DEATHS

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF DEATH

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BUREAU V. S.

APR 16 1956

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1-11-56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03535

3589

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Boyce Last Boyce				4. DATE OF DEATH Month 4 Day 4 Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1912	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 19 Min. 56		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Frank Boyce		14. MOTHER'S MAIDEN NAME Margaret Collison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records and wife, Helen Boyce		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Atrophy DUE TO (c) Traumatic Epilepsy						INTERVAL BETWEEN ONSET AND DEATH 3 days Unknown - no. of years "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 4/2 , 19 56 , to 4/4 , 19 56 , that I last saw the deceased alive on 4/3 , 19 56 , and that death occurred at 3:30z AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/4/56 ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/7/56		22c. NAME OF CEMETERY OR CREMATORY Cokers		22d. LOCATION (City, town, or county) (State) Greensboro Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais				ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR DATE 4-7-56	
24b. REGISTRAR'S SIGNATURE K. M. [Signature]							

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APR 10 1956

BUREAU V.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03536

3590

CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUISE Middle FRANCE Last BRANDT		4. DATE OF DEATH Month Apr Day 12 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1900
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry L. France		14. MOTHER'S MAIDEN NAME Mary Coggins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. --	
17. INFORMANT Milton W. Brandt		Address Churchton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CACHEXIA 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic CA - Breast. DUE TO (c) Adenocarcinoma - Left Breast.		INTERVAL BETWEEN ONSET AND DEATH 3 days 1 mo 5 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 55 , to 12 Apr , 19 56 , that I last saw the deceased alive on 12 Apr , 19 56 , and that death occurred at 10:54 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Sasser M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 4-12-56	
PHYSICIAN'S NAME (Type) R. B. SASSER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/16/56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. News Co.		24a. REC'D BY REGISTRAR April 13-56	
ADDRESS 2901 14th St. N.W. Washington 9, D.C.		24b. REGISTRAR'S SIGNATURE J. B. Went	

CERTIFICATE OF DEATH

3500

PLACE OF BIRTH Anne Arundel		PLACE OF BIRTH Maryland	
NAME OF DECEASED Mary Ann		NAME OF DECEASED Mary Ann	
DATE OF BIRTH 1900		DATE OF BIRTH 1900	
SEX Female		SEX Female	
RACE White		RACE White	
OCCUPATION Housewife		OCCUPATION Housewife	
MARITAL STATUS Single		MARITAL STATUS Single	
PLACE OF DEATH Baltimore		PLACE OF DEATH Baltimore	
DATE OF DEATH 1956		DATE OF DEATH 1956	
TIME OF DEATH 10:00 AM		TIME OF DEATH 10:00 AM	
CAUSE OF DEATH Heart Disease		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. Edgar		SIGNATURE OF PHYSICIAN J. Edgar	
SIGNATURE OF CORONER J. Edgar		SIGNATURE OF CORONER J. Edgar	
SIGNATURE OF WITNESS J. Edgar		SIGNATURE OF WITNESS J. Edgar	

BUREAU V. S.

APR 16 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3552

CERTIFICATE OF DEATH

Reg. Dist. No. 21

03537

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel County</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 College Creek Terrace</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Peterson</u> Last <u>Brewer</u>			4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/1879</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>William Ayers</u>			14. MOTHER'S MAIDEN NAME <u>Moriah Sparrow</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			17. INFORMANT <u>Lillian Insey, 2 College Creek Terrace</u>		
16. SOCIAL SECURITY NO. <u>No</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>12 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>9/22</u> , 19 <u>55</u> , to <u>4/15</u> , 19 <u>56</u> , that I lost the deceased alive on <u>4/15</u> , 19 <u>56</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>37 Calvert St., Annapolis, Md.</u> DATE SIGNED _____					
ACTUAL SIGNATURE <u>Theodore H. Johnson, Jr.</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Dr. Theodore H. Johnson, Jr.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>4-18-56</u>	<u>Brewer Hill</u>		<u>Annapolis, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>		ADDRESS <u>Annapolis, Md</u>		24a. REC'D BY REGISTRAR DATE <u>4-25-1956</u>	24b. REGISTRAR'S SIGNATURE <u>W. Reese</u>

CERTIFICATE OF DEATH

3503

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		MD		USA		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		10 DAYS		APR 25 1956		BALTIMORE		MD		USA		USA	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED
APR 26 1956
BUREAU V. 1

Reg. Dist. No.

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

3503

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1956

BUREAU V. 8

APR 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3591

CERTIFICATE OF DEATH

03539

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Aundel County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Crownsville State Hospital</u>		d. STREET ADDRESS <u>Ridgely</u> <u>Crownsville</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John</u> <u>Brown</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>21</u> , 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Ridgely, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary Anemia</u> <u>159X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Probable Gastro-Intestinal Carcinoma</u> DUE TO (c) <u>Undet.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/26/56</u> , 19 <u>56</u> , to <u>4/21/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/21/56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>April 21, 1956</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Benedict</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>		22d. LOCATION (City, town, or county) (State) <u>Near Goldsboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouclair</u>		24a. REC'D BY REGISTRAR <u>April 21</u>	
ADDRESS <u>Greenelore, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

APR 24 1956

RECEIVED

3564

CERTIFICATE OF DEATH

03540

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp</u>				d. STREET ADDRESS <u>97 Prince George St</u>			
3. NAME OF DECEASED (Type or print) <u>T. ROLAND BROWN</u>				4. DATE OF DEATH <u>April 26 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14, 1869</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Stone Mason</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>T. Travis Brown</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Burges</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Miss S.O. Clayton</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro intestinal Hemorrhage</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Stomach</u> DUE TO <u>unknown</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1955</u> to <u>26 April, 1956</u> , that I last saw the deceased alive on <u>26 April, 1956</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				41 Southgate Ave, Annapolis Md.			
PHYSICIAN'S NAME (Type) <u>Edward S. Beck M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> Son <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>4-30-1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH	
6. PLACE OF BIRTH		7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. DATE OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. PLACE OF DEATH		17. TIME OF DEATH		18. TEMPERATURE		19. PULSE		20. RESPIRATION	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF PHYSICIAN		25. SIGNATURE OF REGISTRAR	

BUREAU V. S.

MAY 2 1956

RECEIVED

3592

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>MD</u> DC	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HARVEST/HARVEST/INVER</u>	47X
X TOWN <u>Lauve</u>		STREET ADDRESS <u>11111111111111111111</u>	Washington
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Children's Center</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<u>Cecil</u> <u>Butler</u>		<u>April</u> <u>27</u> <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5-18-30</u>
9. AGE last birthday <u>25</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>9</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	11. BIRTHPLACE (State or foreign country): <u>Dist of Columbia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Robert Preston Butler</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Gilroy</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Lympho sarcoma</u>			<u>6 to 12 mo</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition</u>			<u>6 mo</u>
19A. DATE OF OPERATION: <u>None</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>August</u> , 19 <u>55</u> , to <u>27 April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 April</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Francis M. Marshota</u>		DATE SIGNED <u>28 April 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>None</u>		DATE THEREOF <u>4-28-56</u>	NAME OF CEMETERY OR CREMATORY <u>District Training School</u>
24. FUNERAL DIRECTOR <u>John Brown</u>		ADDRESS <u>1075 Laurel Md</u>	

BUREAU V. F.

MAY 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3565

CERTIFICATE OF DEATH

03542

Reg. Dist. No. 1

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General Hospital</u>		d. STREET ADDRESS <u>33 Maryland Ave</u> 1	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>R.</u> Last <u>CASSIDY</u>		4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>27</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent for Life Insurance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Annapolis Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Cassidy</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>A.C. DAVIS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/10</u> , 19 <u>56</u> , to <u>4/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/13</u> , 19 <u>56</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John H. Hedrow</u>		ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis Md.</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>		DATE SIGNED <u>4/13/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr 15-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St James Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR DATE <u>4-16-1956</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>	

BUREAU V.

APR 17 1955

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3593

CERTIFICATE OF DEATH

03543

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Ohio</u>		COUNTY <u>Lucas</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort GG Meade, Md</u>		LENGTH OF STAY (in this place) <u>10 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Toledo</u>		<u>72X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>845 Rochelle Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>BRIAN</u> (Middle) <u>KEITH</u> (Last) <u>CHRISTY</u>				(Month) <u>April</u> (Day) <u>8</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>8 April 1956</u>	
9. AGE last birthday <u>8</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harold Woodrow Christy</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Edwards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Father: Harold Christy, 8029 Midhave Rd, Balto., Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						8 hrs 50 min	
762.5 IMMEDIATE CAUSE (A) <u>Atelectasis</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8 April 1956</u> , to <u>8 April 1956</u> , that I last saw the deceased alive on <u>8 April 1956</u> , and that death occurred at <u>9:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Herbert L. Needleman</u> M.D.				ADDRESS (Street, city, town, state) <u>Fort George G. Meade, Md.</u>		DATE SIGNED <u>8 April 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-11-56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>10 Apr 56</u>		REGISTRAR'S SIGNATURE <u>W.L. SAYLOR, 1/Lt MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>WM. COOK, INC.</u>		BALTO., MD ADDRESS	

2 50294240

CERTIFICATE OF DEATH

9509

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS	
28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS	
34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
37. SIGNATURE OF WITNESS		38. SIGNATURE OF WITNESS		39. SIGNATURE OF WITNESS	
40. SIGNATURE OF WITNESS		41. SIGNATURE OF WITNESS		42. SIGNATURE OF WITNESS	
43. SIGNATURE OF WITNESS		44. SIGNATURE OF WITNESS		45. SIGNATURE OF WITNESS	
46. SIGNATURE OF WITNESS		47. SIGNATURE OF WITNESS		48. SIGNATURE OF WITNESS	
49. SIGNATURE OF WITNESS		50. SIGNATURE OF WITNESS		51. SIGNATURE OF WITNESS	
52. SIGNATURE OF WITNESS		53. SIGNATURE OF WITNESS		54. SIGNATURE OF WITNESS	
55. SIGNATURE OF WITNESS		56. SIGNATURE OF WITNESS		57. SIGNATURE OF WITNESS	
58. SIGNATURE OF WITNESS		59. SIGNATURE OF WITNESS		60. SIGNATURE OF WITNESS	
61. SIGNATURE OF WITNESS		62. SIGNATURE OF WITNESS		63. SIGNATURE OF WITNESS	
64. SIGNATURE OF WITNESS		65. SIGNATURE OF WITNESS		66. SIGNATURE OF WITNESS	
67. SIGNATURE OF WITNESS		68. SIGNATURE OF WITNESS		69. SIGNATURE OF WITNESS	
70. SIGNATURE OF WITNESS		71. SIGNATURE OF WITNESS		72. SIGNATURE OF WITNESS	
73. SIGNATURE OF WITNESS		74. SIGNATURE OF WITNESS		75. SIGNATURE OF WITNESS	
76. SIGNATURE OF WITNESS		77. SIGNATURE OF WITNESS		78. SIGNATURE OF WITNESS	
79. SIGNATURE OF WITNESS		80. SIGNATURE OF WITNESS		81. SIGNATURE OF WITNESS	
82. SIGNATURE OF WITNESS		83. SIGNATURE OF WITNESS		84. SIGNATURE OF WITNESS	
85. SIGNATURE OF WITNESS		86. SIGNATURE OF WITNESS		87. SIGNATURE OF WITNESS	
88. SIGNATURE OF WITNESS		89. SIGNATURE OF WITNESS		90. SIGNATURE OF WITNESS	
91. SIGNATURE OF WITNESS		92. SIGNATURE OF WITNESS		93. SIGNATURE OF WITNESS	
94. SIGNATURE OF WITNESS		95. SIGNATURE OF WITNESS		96. SIGNATURE OF WITNESS	
97. SIGNATURE OF WITNESS		98. SIGNATURE OF WITNESS		99. SIGNATURE OF WITNESS	
100. SIGNATURE OF WITNESS		101. SIGNATURE OF WITNESS		102. SIGNATURE OF WITNESS	

BUREAU V. S.

APR 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 197 5-16-56 et

CERTIFICATE OF DEATH

03544

28

Reg. Dist. No.

3594

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hosp.</u>				d. STREET ADDRESS <u>1106 Woodyear Street</u>			
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Clark</u> Middle Last				4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>03/08/82</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u> Hours <u>15</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Clark</u>		14. MOTHER'S MAIDEN NAME <u>Martha Gross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Lula Mae Clark</u> wife		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive Pulmonary Tuberculosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u> <u>Undet.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>06/20/49</u> , 19____, to <u>4/28/56</u> , 19____, that I last saw the deceased alive on <u>4/27/56</u> , 19____, and that death occurred at <u>1:15a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. W. Whitt</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Leon W. Whitt</u>				M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Int. Autumn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>West Port Balto md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Metropolitan Funeral Home Inc.</u>				ADDRESS <u>1130 N. Helms</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>26. M. Joyce</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF BIRTH		DATE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		PLACE OF INTERMENT	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAY 1 1956

RECEIVED

2/3/25 Dist. Jackson Co. Md. West 1st Dist. Court
1152 N. ...
...

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03545

3595 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burro, Glen Burnie</u>		LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Burro, Glen Burnie</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>112 Stevens Rd.</u>				STREET ADDRESS (If rural give location) <u>112 Stevens Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>Willie Lee Clark</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 22 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 30, 1886</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George C. Clark Hill</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Margaret May Davidson</u> <u>112 Stevens Rd</u> <u>Glen Burnie</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
2041 IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Adenocarcinoma</u>						<u>6 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Acute Myeloid Leukemia</u>						<u>9 mos</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senility</u>						<u>10 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/11 9:30</u> to <u>4/22 56</u> , that I last saw the deceased alive on <u>4/22 56</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Paul Richard</u>		M.D. <u>715 Carter Rd</u>		ADDRESS (Street, city, town, state) <u>Balto., Md.</u>		DATE SIGNED <u>4/22/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. REC'D BY REGISTRAR <u>APR 25 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. DeBella</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edm. J. Lickner & Sons</u>		ADDRESS <u>Balto., Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3596

CERTIFICATE OF DEATH

03546

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2½ months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS Homeless			
3. NAME OF DECEASED (Type or print) First Charles Middle Crumby alias Clundy Last Clundy				4. DATE OF DEATH Month 4 Day 21 Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/21/09	
9. AGE (In years last birthday) yrs. 46		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Edward Clundy				14. MOTHER'S MAIDEN NAME Roberta Nickens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bulbar Palsy Known to us since 4/16/56 DUE TO (b) Amiotrophic Lateral Sclerosis Unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crownsville, Md.				20g. (County) Thomasville		20h. (State) Georgia	
21. I certify that I attended the deceased from 4/16 , 19 56 , to 4/21 , 19 56 , that I last saw the deceased alive on 4/20 , 19 56 , and that death occurred at 9:55 p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissmann M.D.				DATE SIGNED 4/22/56			
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4-29-56		22c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery		22d. LOCATION (City, town, or county) (State) Thomasville Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis, Md				24a. REC'D BY REGISTRAR DATE 4-28-56		24b. REGISTRAR'S SIGNATURE H m Soyce	

CERTIFICATE OF DEATH

3536

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES C. HARRIS		MALE		45		JAN 15 1910		BALTIMORE, MD.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
LABORER		HEART DISEASE		NATURAL		MAY 1 1956		BALTIMORE, MD.	
PREVIOUS ILLNESS		SYMPTOMS		TREATMENT		HISTORY		FAMILY HISTORY	
NONE		Chest pain, shortness of breath		Medicine, rest		None		None	
MEDICAL ATTENDANCE		NAMES OF PHYSICIANS		HOSPITAL		NAMES OF SURGEONS		NAMES OF ASSISTANTS	
YES		DR. J. H. SMITH		BALTIMORE HOSPITAL		DR. J. H. SMITH		DR. J. H. SMITH	
DATE OF EXAMINATION		BY WHOM EXAMINED		SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF ASSISTANT	
MAY 1 1956		J. H. SMITH		J. H. SMITH		J. H. SMITH		J. H. SMITH	

BUREAU V. S.

MAY 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3597 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03547

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>12 y.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Thelma Avenue</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Lee</u> Last <u>Cogle</u> 4. DATE OF DEATH Month <u>April</u> Day <u>6th.</u> Year <u>19 56</u>				5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>8/27/81</u> 9. AGE (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Railroad Employee</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Jefferson Co. W. Virginia.</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jonathan Cogle</u> 14. MOTHER'S MAIDEN NAME <u>Lucy Derry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u>212-14-0319</u> 17. INFORMANT <u>Mrs. Lucy Cogle (Sister in law)</u> Address <u>Same address.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>General Ateriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> 20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4/6/56</u> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>April 9, 56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Harpers Ferry, West Virginia</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Kirkley</u> 24a. REC'D BY REGISTRAR <u>James S. Kirkley, 421 Crain Highway, Glen Burnie</u> 24b. REGISTRAR'S SIGNATURE <u>L. G. Seall</u> DATE <u>APR 11 1956</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 11 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03549

3598

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>A.A. Co</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>A.A. Co</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<i>X</i> <i>BAY SIDE BEACH</i>		<i>8 yrs</i>		<i>BAY SIDE BEACH</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>00</i> <i>APPLETREE ROAD</i>				<i>APPLETREE RD</i>		<i>R. F. D. 2 BOX 375</i>	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>RENA - CORKRAN</i>				<i>April 2 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>FEMALE</i>	<i>WHITE</i>	<i>Widowed</i>	<i>August 20, 1873</i>	<i>82</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>HOUSEWIFE</i>				<i>BALTIMORE Md</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>?</i>				<i>?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>NO</i>		<i>NONE</i>		<i>Edw. J. Corkran Bay Side Beach Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<i>332X</i> <i>acute cerebral thrombosis</i>				<i>1/2 hour</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<i>generalized arteriosclerosis unknown</i>			
DUE TO (B)							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>none</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Mar 31, 1954</i> to <i>April 1, 1956</i> , that I last saw the deceased alive on <i>Mar 31, 1956</i> , and that death occurred at <i>9:15 PM</i> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>R. M. McLaughlin</i>				<i>Pasadena, Md.</i>		<i>April 9, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>4/5/1956</i>		<i>GLENN HAVEN Cem</i>		<i>A. A. Co Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>April 3, 1956</i>		<i>L. J. DeAlba</i>		<i>101 MC + B. M. Walters</i>		<i>STARKER ST</i>	

1

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03550

3599

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Severna Park</u>		<u>18 yrs</u>		TOWN <u>Severna Park</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 25 - Bentfield Rd.</u>				STREET ADDRESS (If rural give location) <u>Box 25 - Bentfield Road</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Tosiah Avery Cox</u>				<u>April 26, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>June 12, 1896</u>	<u>60</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Secretary of Dept. E-L-A Local #1510</u>				<u>Fairmount, MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Elijah J. Cox</u>				<u>Ella J. Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>W.W. I</u>		<u>213-12-6855</u>		<u>Mrs. Helen E. Cox Box 25 Severna Pk., MD</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						15. MEDICAL CERTIFICATION	
463X IMMEDIATE CAUSE (A)						Pulmonary embolus bilateral	
ANTECEDENT CAUSE(S) DUE TO						30 minutes	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						Varicose veins left lower extremity	
(B) DUE TO						Gastrointestinal hemorrhage	
(C) DUE TO							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 18, 1956, to April 26, 1956, that I last saw the deceased alive on April 26, 1956, and that death occurred at 10:30 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Francis J. Codd M.D.</u>				<u>Box 289 Severna Park Md 4-30-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 30, 1956</u>		<u>Glen Haven</u>		<u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>5/3/56</u>		<u>L. G. Tallha</u>		<u>John B. King</u>		<u>John B. King, Md.</u>	

CERTIFICATE OF DEATH

8582

Reg. Dist. No.

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE (Years, Months, Days)

4. OCCUPATION

5. PLACE OF BIRTH (Country, State, County, City, Town, Village)

6. DATE OF BIRTH (Month, Day, Year)

7. PLACE OF DEATH (Country, State, County, City, Town, Village)

8. DATE OF DEATH (Month, Day, Year)

9. TIME OF DEATH (Hour, Minute)

10. CAUSE OF DEATH (Print or Write)

11. PLACE OF INTERMENT (Country, State, County, City, Town, Village)

12. DATE OF INTERMENT (Month, Day, Year)

13. TIME OF INTERMENT (Hour, Minute)

14. SIGNATURE OF DECEASED (Print or Write)

15. SIGNATURE OF WITNESSES (Print or Write)

16. SIGNATURE OF PHYSICIAN (Print or Write)

17. SIGNATURE OF CLERK (Print or Write)

18. SIGNATURE OF REGISTRAR (Print or Write)

19. SIGNATURE OF JUDGE (Print or Write)

20. SIGNATURE OF SHERIFF (Print or Write)

21. SIGNATURE OF CLERK (Print or Write)

22. SIGNATURE OF REGISTRAR (Print or Write)

23. SIGNATURE OF JUDGE (Print or Write)

24. SIGNATURE OF SHERIFF (Print or Write)

25. SIGNATURE OF CLERK (Print or Write)

26. SIGNATURE OF REGISTRAR (Print or Write)

27. SIGNATURE OF JUDGE (Print or Write)

28. SIGNATURE OF SHERIFF (Print or Write)

29. SIGNATURE OF CLERK (Print or Write)

30. SIGNATURE OF REGISTRAR (Print or Write)

31. SIGNATURE OF JUDGE (Print or Write)

32. SIGNATURE OF SHERIFF (Print or Write)

33. SIGNATURE OF CLERK (Print or Write)

34. SIGNATURE OF REGISTRAR (Print or Write)

35. SIGNATURE OF JUDGE (Print or Write)

36. SIGNATURE OF SHERIFF (Print or Write)

37. SIGNATURE OF CLERK (Print or Write)

38. SIGNATURE OF REGISTRAR (Print or Write)

39. SIGNATURE OF JUDGE (Print or Write)

40. SIGNATURE OF SHERIFF (Print or Write)

41. SIGNATURE OF CLERK (Print or Write)

42. SIGNATURE OF REGISTRAR (Print or Write)

43. SIGNATURE OF JUDGE (Print or Write)

44. SIGNATURE OF SHERIFF (Print or Write)

45. SIGNATURE OF CLERK (Print or Write)

46. SIGNATURE OF REGISTRAR (Print or Write)

47. SIGNATURE OF JUDGE (Print or Write)

48. SIGNATURE OF SHERIFF (Print or Write)

49. SIGNATURE OF CLERK (Print or Write)

50. SIGNATURE OF REGISTRAR (Print or Write)

51. SIGNATURE OF JUDGE (Print or Write)

52. SIGNATURE OF SHERIFF (Print or Write)

53. SIGNATURE OF CLERK (Print or Write)

54. SIGNATURE OF REGISTRAR (Print or Write)

55. SIGNATURE OF JUDGE (Print or Write)

56. SIGNATURE OF SHERIFF (Print or Write)

57. SIGNATURE OF CLERK (Print or Write)

58. SIGNATURE OF REGISTRAR (Print or Write)

59. SIGNATURE OF JUDGE (Print or Write)

60. SIGNATURE OF SHERIFF (Print or Write)

61. SIGNATURE OF CLERK (Print or Write)

62. SIGNATURE OF REGISTRAR (Print or Write)

63. SIGNATURE OF JUDGE (Print or Write)

BUREAU V. S.

MAY 3 1956

RECEIVED

2007041002

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03551

3600

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shadyside</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Shadyside</i>		d. STREET ADDRESS <i>Shadyside</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Hugh Ward Crowner</i>		4. DATE OF DEATH Month <i>4</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OF RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-21-29</i>
9. AGE (In years lost birthday) <i>26</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hosp. Attendant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Crownsville State Hosp.</i>	
11. BIRTHPLACE (State or foreign country) <i>Shadyside, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James A. Crowner</i>		14. MOTHER'S MAIDEN NAME <i>Aurida Scott</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>Korea</i>		16. SOCIAL SECURITY NO. <i>213-28-2419</i>	
17. INFORMANT <i>Emily Crowner - Shadyside, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart and Skull.</i> <i>825X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Auto accident</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Auto accident</i>	
20c. TIME OF INJURY Month, Day, Year <i>4 14 1956</i> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Road</i>		20f. (City or town) <i>Shadyside</i> (County) <i>A.A. & ind.</i> (State)	
21. I certify that I attended the deceased from <i>not at all</i> to <i>not at all</i> , 19 <i>not at all</i> , that I last saw the deceased alive on <i>not at all</i> , 19 <i>not at all</i> , and that death occurred at <i>2 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Emily H. Nelson</i> M.D.		ADDRESS (Street, city or town, state) <i>Shadyside, Md.</i> DATE SIGNED <i>4/16/56</i>	
PHYSICIAN'S NAME (Type) <i>acting crowner</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-17-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. Matthews</i>		22d. LOCATION (City, town, or county) <i>Shadyside, Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Keese, Jr. - Annapolis, Md</i>		24a. REC'D BY REGISTRAR <i>4/17/56</i> 24b. REGISTRAR'S SIGNATURE <i>Eda Belle Smith</i>	

BUREAU V. 81

APR 17 1956

RECEIVED

Reg. Dist. No. 2

1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>313 4th St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LEO</u> First <u>R. CROWTHERS</u> Middle <u>CROWTHERS</u> Last		4. DATE OF DEATH <u>April</u> Month <u>20</u> Day <u>1956</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/1899</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARTENDER</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>BARTENDER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN CROWTHERS</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARY D. CROWTHERS</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart disease</u> 4343 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Annapolis, Md.</u>		DATE SIGNED <u>4/20/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/23/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Mo.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. [Signature]</u>		24a. REC'D BY REGISTRAR DATE <u>4-23-1956</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the case executive the certificate, [redacted] the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chicago Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

APR 24 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03553

3601

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>51 USNH, Annapolis</u>		d. STREET ADDRESS <u>32 Sellers Rd, Arundel Estates</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miriam Gilchrist Cummings</u>		4. DATE OF DEATH Month Day Year <u>April 22 19 56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-11-26</u>
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Utah</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Elvin Willes Gilchrist</u>		14. MOTHER'S MAIDEN NAME <u>Lois B Cowley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Naval Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries, Multiple, Skull N 803</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>2:30 p.m. April 22 1956</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) (County) (State) <u>Rural Annapolis AA Md</u>	
21. I certify that I attended the deceased from <u>4-22</u> , 19 <u>56</u> , to <u>4-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-22</u> , 19 <u>56</u> , and that death occurred at <u>11:45a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P.O. Geib</u> P.O. GEIB CDR MC USN		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Annapolis, Md</u>	
DATE SIGNED <u>11-23-56</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal 3-23-56</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethelton Pa.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>800 Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>11</u>		24b. REGISTRAR'S SIGNATURE <u>U. S. Naval</u>	
DATE <u>4-23-1956</u>			

02

02-11-

X

Figure 10. The effect of the initial concentration of the monomer on the polymerization of *l*-lysine.

BOREAU V. S.

APR 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3602

CERTIFICATE OF DEATH

03554
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN b. 57 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Crownsville State Hospital		d. STREET ADDRESS 1347 N. Calhoun Street	
3. NAME OF DECEASED (Type or print) First Samuel Middle Darling Last Darling		4. DATE OF DEATH Month 4 Day 22 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1881
9. AGE (In years last birthday) 75? yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (State or foreign country) Not given		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Known to us since 2/25/56 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/25 , 19 56 , to 4/22 , 19 56 , that I last saw the deceased alive on 4/21 , 19 56 , and that death occurred at 6:55a M. from the causes and on the date stated above. ACTUAL SIGNATURE L. Benedict M.D. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 4/23/56 PHYSICIAN'S NAME (Type) L. Benedict			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/28/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hollander Funeral Home 1631 - Druid Hill Ave		24a. REC'D BY REGISTRAR APR 30 1956	
24b. REGISTRAR'S SIGNATURE L. M. Joyce			

3623

03555

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		08x-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Rte. #1, Box 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Dorothy		First Dorothy		Middle Davis		Last Davis			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-22-25			
9. AGE (In years last birthday) yrs. 30		IF UNDER 1 YEAR Months 4		Day 22		Year 19 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME James Davis				14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subacute Yellow Atrophy of the Liver 580x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Allergy probably to Barbiturates DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deficiency, Severe (Congenital)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -							
20c. TIME OF INJURY Hour a. 1 Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -		20f. (City or town) (County) (State) - - - - -			
21. I certify that I attended the deceased from 4/7 , 19 56 to 4/22 , 19 56 , that I last saw the deceased alive on 4/20 , 19 56 , and that death occurred at 10:30 a.m. from the causes and on the date stated above. Hildegard Heard Reissmann M.D. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/23/56									
ACTUAL SIGNATURE Hildegard Heard Reissmann									
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann									
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 25		22c. NAME OF CEMETERY OR CREMATORY St. Anne's Catholic Church		22d. LOCATION (City, town, or county) (State) Indian Head Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Johnson and Jenkins				ADDRESS 1702 1/2 St.		24a. REC'D BY REGISTRAR DATE 4-22-56			
						24b. REGISTRAR'S SIGNATURE H. M. ...			

3003
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 CERTIFICATE OF DEATH

NAME OF DECEASED John A. Smith		SEX Male		AGE 45		DATE OF BIRTH Jan 15, 1900		PLACE OF BIRTH Baltimore, Md.	
FATHER'S NAME John A. Smith		MOTHER'S NAME Mary E. Smith		DECEASED'S RESIDENCE 1234 Main St., Baltimore, Md.		DECEASED'S OCCUPATION Teacher		DECEASED'S MARITAL STATUS Married	
DATE OF DEATH Apr 10, 1956		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		DECEASED'S RELIGION Roman Catholic	
DECEASED'S SIGNATURE John A. Smith		DECEASED'S ADDRESS 1234 Main St., Baltimore, Md.		DECEASED'S PHONE NO. 123-4567		DECEASED'S SOCIAL SECURITY NO. 123-45-6789		DECEASED'S GRAVE NO. 1234	
DECEASED'S GRAVE NO. 1234		DECEASED'S GRAVE NO. 1234		DECEASED'S GRAVE NO. 1234		DECEASED'S GRAVE NO. 1234		DECEASED'S GRAVE NO. 1234	

RECEIVED
 APR 25 1956
 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3557

CERTIFICATE OF DEATH

03556

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>A.A. General Hosp.</i>		d. STREET ADDRESS <i>Box 131 R.F.D.</i>	
3. NAME OF DECEASED (Type or print) First <i>Edith</i> Middle <i>Davis</i> Last <i>Davis</i>		4. DATE OF DEATH Month <i>4</i> Day <i>26</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-4-1896</i>
9. AGE (In years last birthday) <i>60</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>David Dorsey Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Mary Easton</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>	
17. INFORMANT <i>David Dorsey Jr.</i>		Address <i>Edgewater, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage due to Hypertension</i> DUE TO <i>2 Right Hemiparesis</i> (b) <i>Arteriosclerosis</i> (c) <i>Hypertensive Cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4/21</i> , 19 <i>56</i> , to <i>4/26</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4/26</i> , 19 <i>56</i> , and that death occurred at <i>12:15</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edith Davis</i>		ADDRESS (Street, city or town, state) <i>110 - Clay Street</i> DATE SIGNED <i>4/27/56</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-29-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Carter Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Friendship Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese Jr.</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>5/7/1956</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. O'Donoghue</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased		C. L. Howard	
Sex		Male	
Age		37	
Date of Birth		1874-1-1	
Place of Birth		Maryland	
Cause of Death		Typhoid Fever	
Date of Death		1914-1-1	
Place of Death		Home	
Signature of Physician		J. H. Howard	
Signature of Registrar		J. H. Howard	

BUREAU V. S.

MAY 8 1914

RECEIVED

General Hospital - Chicago, Ill. Mr. J. H. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03557

3604

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 9 mos. 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Collins Street	
3. NAME OF DECEASED (Type or print) First James Middle Dennis Last Dennis		4. DATE OF DEATH Month 4 Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 78?		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Dennis		14. MOTHER'S MAIDEN NAME Ella Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 226-18-0813	
17. INFORMANT Hospital Records, Crownsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure with Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Degeneration DUE TO (c) Syphilis and Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 6 weeks Known to us since 6/28/55 "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/28/1955 , to 4/24/1956 , that I last saw the deceased alive on 4/24/1956 , and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Heard Reissmann		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/25/56	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-29-56	
22c. NAME OF CEMETERY OR CREMATORY St. A. Cemetery		22d. LOCATION (City, town, or county) (State) St. A. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson		24a. REC'D BY REGISTRAR DATE 5/5/56	
ADDRESS 916 Pennsylvania		24b. REGISTRAR'S SIGNATURE W. H. Jones	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. S.

MAY 3 1956

RECEIVED

Form with fields for recording information, including a date field showing 5-2-56 and a signature line.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3605

CERTIFICATE OF DEATH

03558

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA.</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore 25</u>		<u>2 yrs.</u>		TOWN <u>Linthicum</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Ave -</u>				STREET ADDRESS (If rural give location) <u>Main Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Clara</u> (Middle) <u>Ethel</u> (Last) <u>Downs</u>				(Month) <u>April</u> (Day) <u>1</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 9 - 1881</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward McDaniel</u>				14. MOTHER'S MAIDEN NAME <u>Luella Powers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Doris Anderson</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>Cardio Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				<u>17 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 16</u> , 19 <u>55</u> , to <u>4/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/1/56</u> , 19 <u>56</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Chas L. Ball</u>		M.D. <u>Linthicum</u>		ADDRESS (Street, city, town, state) <u>4101 Edmondson Ave</u>		DATE SIGNED <u>4/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>Apr. 3, 1956</u>		REGISTRAR'S SIGNATURE <u>Ada Whitson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wigley</u>		ADDRESS <u>4101 Edmondson Ave</u>	

RECEIVED

3568

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 A.A. GENERAL</u>				d. STREET ADDRESS <u>PRINCE GEORGE</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ROSEMARY</u> Middle <u>DOYLE</u> Last <u>DOYLE</u>				4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/1895</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. N.E.E.S.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES G. DOYLE</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE DOWAVAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. J. Doyle</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>430.0 Cerebrovascular accident</u> DUE TO (b) <u>Postnatal endocarditis</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>4/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/17</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md</u> DATE SIGNED <u>4/19/56</u>							
ACTUAL SIGNATURE <u>John H. Henderson</u> M.D.				PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Henderson</u> ADDRESS <u>Annapolis, Md</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>4-19-1956</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 23 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03560

3676

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>412 6th Ave NE</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>AA</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> TOWN <u>Glen Burnie</u> STREET ADDRESS (If rural give location) <u>412 6th Ave NE</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>ELMA</u> (Middle) <u>EVELYN</u> (Last) <u>FRIEND</u>				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>20</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Oct 23, 1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. McCollough</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. Lypic</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>MRS Mary Buckingham, Same as 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0</u> IMMEDIATE CAUSE (A) <u>Coronary artery occlusion</u> ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerotic heart disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u> </u> (C) <u> </u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6:30 P.</u> , to <u> </u> , 19 <u>56</u> , that I last saw the deceased alive on <u> </u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above. SIGNATURE <u>Joseph Taker</u> ADDRESS (Street, city, town, state) <u>102 Balto-Hann Rd, Md. 4/20/1956</u> M.D. <u>M. E. Glen Burnie, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial + Rem.</u>		DATE THEREOF <u>4/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>FRIENDSVILLE</u>		LOCATION (City, town, or county) (State) <u>FRIENDSVILLE, Md</u>	
24. REC'D BY REGISTRAR <u> </u>		REGISTRAR'S SIGNATURE <u>L. J. Dealba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Kirkley</u> ADDRESS <u>Hopping + Kirkley Glen Burnie Md</u>			
DATE <u>April 21, 56</u>							

CERTIFICATE OF DEATH

FILE NO.

MAJOR DISPOSITION (For use by Registrar)

1. NAME OF DECEASED	2. SEX	3. AGE	4. DATE OF BIRTH	5. PLACE OF BIRTH	6. OCCUPATION	7. MARITAL STATUS	8. CAUSE OF DEATH	9. MANNER OF DEATH	10. PLACE OF DEATH	11. TIME OF DEATH	12. SIGNATURE OF REGISTRAR	13. SIGNATURE OF PHYSICIAN	14. SIGNATURE OF FUNERAL HOME	15. SIGNATURE OF WITNESSES
John W. McLaughlin	Male	65	1885	New York	Teacher	Married	Heart Disease	Natural	Home	10:30 AM	[Signature]	[Signature]	[Signature]	[Signature]

BUREAU V. S.

APR 24 1936

RECEIVED

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 235 N. Stricker Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First William		Middle Gaines		Last Gaines	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month 4 Day 6 Year 19 56	
9. AGE (In years last birthday) 78? yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY Not known		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Jesse Gaines		14. MOTHER'S MAIDEN NAME Mary Gaines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO AHCVD *Arteriosclerotic Hypertensive Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Unknown for no. years (c) 1 day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month 4 Day 6 Year 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/26 , 19 56 , to 4/6 , 19 56 , that I last saw the deceased alive on 4/5 , 19 56 , and that death occurred at 8:45 a.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/6/56 ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie B. Williams		ADDRESS Schroeder St.		24a. REC'D BY REGISTRAR APR 11 1956		24b. REGISTRAR'S SIGNATURE L. M. Hayes	

MARI AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

RECEIVED
APR 11 1956
BUREAU V. S.

THESE

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03562

3508

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>536 W. Barre Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Thomas</u> (First) <u>Gantt</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>2</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Not given</u>		9. AGE last birthday <u>76?</u> yrs.	IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Not given</u>				14. MOTHER'S MAIDEN NAME <u>Not given</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Degeneration</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Hypertensive Cardiovascular Dis.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus & Chronic Brain Syndrome</u>						<u>Since 2/30/55</u>	
19a. DATE OF OPERATION - - - - -		19b. MAJOR FINDINGS OF OPERATION - - - - -		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>4/2</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/30</u>, 19 <u>55</u>, to <u>4/2</u>, 19 <u>56</u>, that I last saw the deceased alive on <u>4/2</u>, 19 <u>56</u>, and that death occurred at <u>8:50a</u> a.m., from the causes and on the date stated above.							
SIGNATURE <u>Hildgarth Heard Reimann</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>4/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		LOCATION (City, town, or county) (State) <u>Brooklyn, Maryland</u>	
24. REC'D BY REGISTRAR <u>APR 9 1956</u>		REGISTRAR'S SIGNATURE <u>X. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. O. Wilson</u>		ADDRESS <u>1000 B. ...</u>	

RECEIVED

3609

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Arnold</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William S. Gardner</u>				4. DATE OF DEATH <u>4-18-56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3^d 1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Bldg.</u>		11. BIRTHPLACE (State or foreign country) <u>Arnold Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>
13. FATHER'S NAME <u>James Gardner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Byrnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Elizabeth B. Gardner</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>4-14</u> , 19 <u>56</u> , to <u>4-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-12</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Francis I. Cobb</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>4-19-56</u>			
PHYSICIAN'S NAME (Type) <u>FRANCIS I COBB</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crofton Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Arnold Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md</u>				24a. REC'D BY REGISTRAR <u></u> DATE <u>4-19-1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Donnell</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 1

APR 23 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03564

3610- CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Millersville</u>		<u>2m. and 12 days</u>		<u>Glen Burnie</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>404- V1 Avenue N.E.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Margaret</u> (Middle) <u>J.</u> (Last) <u>Gissell</u>				(Month) <u>April</u> (Day) <u>19th</u> (Year) <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/25/66</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Luft</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Rabbe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Sann's Nursing Home Records</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
191X IMMEDIATE CAUSE (A) <u>Hypertensive Cardio Vascular Diseases</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Over 3 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cancer of the skin</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/7/56</u> , 19....., to <u>4/19/56</u> , 19....., that I last saw the deceased alive on <u>4/17/56</u> , 19....., and that death occurred at <u>5.15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Harold A. Pauls</u>				ADDRESS (Street, city, town, state) <u>M.D. Glen Burnie, Md.</u>		DATE SIGNED <u>4/19/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>4/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>26. M. Jay</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cooke, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	
DATE <u>APR 23 1956</u>							

CERTIFICATE OF DEATH

Form 100-101

1. NAME OF DECEASED

2. SEX AND AGE

3. PLACE OF BIRTH

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF JAILER

19. SIGNATURE OF WARDEN

BUREAU V. 2

APR 23 1956

RECEIVED

3611

CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4205 Belle St.</u>				d. STREET ADDRESS <u>4205 Belle St.</u>			
3. NAME OF DECEASED (Type or print) <u>Thomas Leo Ganger</u>				4. DATE OF DEATH <u>4-29</u> 19 <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-1-98</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Family - Same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1</u> <u>peripheral vascular collapse probably</u> DUE TO <u>terminal myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>dyspnea, cyanosis,</u> DUE TO <u>pulmonary emphysema</u> (c) <u>pulmonary emphysema</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>3-4 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/29</u> , 19 <u>56</u> , to <u>4/29/56</u> , that I last saw the deceased alive on <u>4/29/56</u> , and that death occurred at <u>8:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leonard B. Flax, M.D.</u>				DATE SIGNED <u>113 Feb Avenue</u>			
PHYSICIAN'S NAME (Type) <u>Leonard B. Flax, M.D.</u>				ADDRESS <u>Brooklyn Park</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>15</u>		22b. DATE THEREOF <u>5/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClure Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>5/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Adm M. Whitson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

DATE OF DEATH

CITY

STATE

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

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NAME OF WITNESS

BUREAU V. 3

MAY 2 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03566

3612

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i>		COUNTY <i>St. Anne</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Severn RFD</i>		LENGTH OF STAY (in this place) <i>Life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Severn Md Rural</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Quarterfield Road</i>				STREET ADDRESS (If rural give location) <i>Quarterfield Road</i>			
3. NAME OF DECEASED (Type or Print) <i>Louise</i> (First) <i>Griffith</i> (Middle) <i>Griffith</i> (Last)				4. DATE OF DEATH (Month) <i>14</i> (Day) <i>24</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, "DIVORCED" (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb 12, 1898</i>	9. AGE last birthday <i>58</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework Pattern</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Anne Arundel Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Abraham Myers</i>				14. MOTHER'S MAIDEN NAME <i>Mary Hummel</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS <i>Howard Griffith Quarterfield Rd Severn Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A) <i>Bronchial Pneumonia</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days.</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Paralysis Agitans</i>						<i>10 years.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1952, to April 24, 1956, that I last saw the deceased alive on April 24, 1956, and that death occurred at 4:40 P.M. from the causes and on the date stated above.							
SIGNATURE <i>C. MacDonald MD</i>				DATE SIGNED <i>April 24, 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23. FUNERAL DIRECTOR'S SIGNATURE <i>Glen Burnie Md</i>			
DATE <i>APR 30 1956</i>		REGISTRAR'S SIGNATURE <i>L. J. Leath</i>		ADDRESS <i>Severn RFD. Md</i>			

RECEIVED

3513
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RIVIERA BEACH</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RIVIERA BEACH</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CACUET RD.</i>		d. STREET ADDRESS <i>CACUET RD.</i>	
3. NAME OF DECEASED (Type or print) <i>CATHERINE C. GROVE</i>		4. DATE OF DEATH Month <i>4</i> - Day <i>26</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-28-89</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWORK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	9. AGE (In years last birthday) <i>68</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Family</i>		Address <i>SAME</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>170x Bilateral Carcinoma Breast.</i> IMMEDIATE CAUSE (a) <i>170x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>170x</i> DUE TO (c) <i>170x</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 10</i> 19 <i>55</i> to <i>April 26</i> 19 <i>56</i> that I last saw the deceased alive on <i>April 24</i> 19 <i>56</i> and that death occurred at <i>7:00</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John A. Schenck</i>		DATE SIGNED <i>1337 S. Charles St. Baltimore, Md. May 17 1956</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>4-30-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>David Ridge</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>McClurey Funeral Home</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>APR 30 1956</i>		24b. REGISTRAR'S SIGNATURE <i>L. J. Sullivan</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 30 1956

RECEIVED

3614 CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE, OR WRITE PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
 Every item of information should be supplied. Physicians: please write the causes of death clearly and let
 HIS CERTIFICATE MUST BE FILLED THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print) Rev Ebenezer Adolphus Haynes		2. DATE OF DEATH April 29, 1956	
3. PLACE OF DEATH A. Baltimore City, Maryland Jalisco Park		4. USUAL RESIDENCE (Where deceased lived before admission) A. STATE MD B. COUNTY A.A.C.	
B. FULL NAME OF HOSPITAL OR INSTITUTION 6011 Belle Grove Rd		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Balto	
C. Length of stay in Baltimore Yrs. 00 Mos. 00 Days 00		D. STREET ADDRESS (If rural, give location) 6011 Belle Grove Rd	
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH Jan 28, 1886
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		9. AGE (In years last birthday) 70	
10B. KIND OF BUSINESS OR INDUSTRY		BIRTHPLACE (State or foreign country) Georgetown B. W.	
13. FATHER'S NAME Edmund Haynes		12. CITIZEN OF WHAT COUNTRY? B.W.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME —	
16. SOCIAL SECURITY NO.		17. INFORMANT Margaret Haynes	
18. 442X		ADDRESS 6011 Belle Grove Rd	
CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Hypertension Cardio-vascular disease			
DUE TO			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) —			
DUE TO			
(C) —			
INTERVAL BETWEEN ONSET AND DEATH 5 +			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2-12-1948 to 4-29-1956 , that (I) (we) last saw the deceased alive on 4-28-1956 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
23A. SIGNATURE Thomas W. Harris		23B. ADDRESS 1824 W. Franklin St	
23C. DATE SIGNED 4-30-56			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE May 4, 1956	
24C. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		24D. LOCATION (City, town, or county) (State) Wash D.C.	
DATE RECEIVED BY LOCAL REGISTRAR 5-3-56		REGISTRAR'S SIGNATURE A. N. Hedrick	
FUNERAL DIRECTOR George S. Nelson		ADDRESS 1348 N. Calhoun St	

MEDICERTIFICATION

03200

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1911

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BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1911

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BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
1911

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3615

CERTIFICATE OF DEATH

Reg. Dist. No.

03570

21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel County</u> MARYLAND				STATE <u>Md.</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural- Arnold, Md.</u> LENGTH OF STAY (in this place) <u>?</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 3V01.4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 Grandview Ave.</u>				STREET ADDRESS (If rural give location) <u>924 N. Collington Avenue</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Mary Ellen Herbert</u>				<u>April 7, 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>July 25, 1890</u>	
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Louis Hopper</u>				14. MOTHER'S MAIDEN NAME: <u>Florence V. Carter</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>Mr. Curtis Herbert; 3507 Juneway -Z 13</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						<u>10 weeks</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>hypertensive CVD</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>obesity</u>						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>April 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 7, 1956</u> , and that death occurred at <u>8:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Burton V. Lock MD</u>				ADDRESS <u>M. O. 2936 E. Balto St</u>		DATE SIGNED <u>4/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 10, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-26</u>		REGISTRAR'S SIGNATURE <u>John A. Moran</u>		24. FUNERAL DIRECTOR <u>John A. Moran</u>		ADDRESS <u>3000 E. Baltimore St.</u>	

RECEIVED BY THE SECRETARY OF THE ARMY
WASHINGTON, D. C. 20315

TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

1. [Illegible]
2. [Illegible]
3. [Illegible]
4. [Illegible]
5. [Illegible]
6. [Illegible]
7. [Illegible]
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9. [Illegible]
10. [Illegible]

11. [Illegible]
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13. [Illegible]
14. [Illegible]
15. [Illegible]

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3616

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MD.</u> COUNTY <u>A. A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn Heights</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Severn Heights</u>	
CITY OR TOWN <u>Severn Heights</u>		LENGTH OF STAY (In this place) <u>20 yrs.</u>		STREET ADDRESS <u>Severn Ave.</u>		STREET ADDRESS <u>Severn Ave.</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>Hettich</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>April</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>July 12, 1872</u>	
9. AGE last birthday <u>83</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Artist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lithographer</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Korn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war/pr dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>710</u>		17. INFORMANT & ADDRESS <u>Neice, Friedel Crist</u> <u>Severn Heights</u>		18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
331 X IMMEDIATE CAUSE (A) <u>(1) Pulmonary Edema</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>(2) Cerebral Hemorrhage</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>(3) Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 15, 1955</u> to <u>15 April 1956</u> that I last saw the deceased alive on <u>15 April 1956</u> and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city, town, state) <u>Severna Park Md</u>		DATE SIGNED <u>16 April 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Cemetery</u>		LOCATION (City, town, or county) <u>Annapolis Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. Bell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HAPPERS Funeral Home</u>		ADDRESS	
DATE <u>4-17-56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3617 CERTIFICATE OF DEATH

03573

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MD.</u>		COUNTY <u>A. A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arnold, MD.</u>		LENGTH OF STAY (In this place) <u>2 Yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Belvedere Beach</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Belvedere Beach, MD.</u>		STREET ADDRESS (If rural give location) <u>Arnold, MD.</u>					
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u> (Middle) <u>Christine</u> (Last) <u>Himmel</u>				(Month) <u>April</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Jan. 17 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Adam Kaufman</u>				14. MOTHER'S MAIDEN NAME <u>MARY STupe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>2-0</u>		17. INFORMANT & ADDRESS <u>Daughter, Miss Mildred Himmel, Belvedere Beach, Arnold, A.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>1 Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>2 Hypertensive C. V. Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>3 Generalized Arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1955</u> , 19....., to <u>April 28</u> , 19....., that I last saw the deceased alive on <u>April 28</u> , 19....., and that death occurred at <u>11 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city, town, state) <u>Severna Park MD</u>		DATE SIGNED <u>29 April 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>5/2/56</u>		REGISTRAR'S SIGNATURE <u>L. J. Dillhop</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Kirby</u>		ADDRESS <u>Hopping & Kirkley, Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

100-0141-100

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03574

3618

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Jessup</i>		<i>2 years</i>		TOWN <i>Jessup</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>1</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Haddie Sedonia Hood</i>				<i>4 12 19 56</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Widow</i>	<i>July 10, 1867</i>	<i>88</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Home</i>		<i>Frederick Co.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>William A. Shipley</i>				<i>Catherine E. Fowler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>no</i>		<i>Mrs Charles Day, Jessup Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				<i>Chc Myocarditis</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>General arteriosclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO				<i>Infirmities of age</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>Soulity</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Apr 12, 1956</i>, to <i>Apr 12, 1956</i>, that I last saw the deceased alive on <i>Apr 12, 1956</i>, and that death occurred at <i>7:30 P.</i> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>W. B. Greenbaum</i>				<i>409 Main St Jessup Md</i>		<i>4/13/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>4/15/56</i>		<i>Pine Grove</i>		<i>Mt Airy, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>APR 17 1956</i>		<i>Clara Shipley</i>		<i>Arthur H. Haight</i>		<i>Shippville, Md.</i>	

3018 CERTIFICATE OF DEATH

FILE NO. 100

1. NAME OF DECEASED

2. SEX

3. PLACE OF BIRTH

4. DATE OF BIRTH

5. PLACE OF DEATH

6. DATE OF DEATH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESS

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESS

18. SIGNATURE OF DECEASED

19. SIGNATURE OF WITNESS

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESS

22. SIGNATURE OF DECEASED

23. SIGNATURE OF WITNESS

24. SIGNATURE OF DECEASED

25. SIGNATURE OF WITNESS

BUREAU V. 2

APR 17 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3619 CERTIFICATE OF DEATH

03575
 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANN ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWSVILLE				c. LENGTH OF STAY IN 1b 12 MOS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWSVILLE STATE HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle M. Last JACKSON				4. DATE OF DEATH Month APRIL Day 20 Year 1956			
5. SEX MALE		6. COLOR OR RACE N.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-15-83	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ROBERT JACKSON		14. MOTHER'S MAIDEN NAME —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT anna B. Robinson		Address 109-40 164 st n.y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002X (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CNS LES; CHRONIC BRAIN SYND. ASSOCIATED E ARTERIOSCLEROSIS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) CROWNSVILLE, MD.				20g. (County) CROWNSVILLE, MD.		20h. (State) MD.	
21. I certify that I attended the deceased from 4-19-1955 to 4-20-1956 , that I last saw the deceased alive on APRIL 20, 1956 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Everett W. Cadenhead, Jr.				DATE SIGNED 4-21-56			
PHYSICIAN'S NAME (Type) EVERETT W. CADENHEAD, JR.				ADDRESS (Street, city or town, state) CROWNSVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-56		22c. NAME OF CEMETERY OR CREMATORY mt auburn		22d. LOCATION (City, town, or county) (State) md	
23. FUNERAL DIRECTOR'S SIGNATURE Rev. H. Kelton				ADDRESS 1348 n. Calhoun st		24a. REC'D BY REGISTRAR APR 23 1956	
24b. REGISTRAR'S SIGNATURE J. M. Joyce							

CERTIFICATE OF DEATH

3812

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES J. JONES		M		45		W		1880		MASSACHUSETTS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
APR 24 1952		10:30 AM		HOME		HEART DISEASE		NATURAL		J. J. JONES	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CLERK		16. SIGNATURE OF DEPUTY CLERK		17. SIGNATURE OF ASSISTANT CLERK		18. SIGNATURE OF CHIEF CLERK	
J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES		J. J. JONES	

BUREAU V. S.

APR 24 1952

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 21

3569

1. PLACE OF DEATH o. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY A.A. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.		c. LENGTH OF STAY IN 1b 10		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 05 64 Maryland Ave.				d. STREET ADDRESS 64 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AMY		First AMY		Middle E.		Last JEWELL	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/22/1878	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None (HOME)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jachob E. Popham		14. MOTHER'S MAIDEN NAME Margaret A. Nayden					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Frank Jewell #2		17. INFORMANT Frank Jewell #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic Cardio-Vasc. Disease DUE TO (c) 8 hrs.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1955 , to 4/30, 1956 , that I last saw the deceased alive on 4/30, 1956 , and that death occurred at 7:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Maurice F. Klawans, M.D.		ADDRESS (Street, city or town, state) Annapolis, Md		DATE SIGNED 5/2/56			
PHYSICIAN'S NAME (Type) MAURICE F. KLA WANS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/3/56		22c. NAME OF CEMETERY OR CREMATORY St. Annes		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. G. L. L. L.		ADDRESS Annapolis, Md		24a. REC'D BY REGISTRAR DATE 5/4/1956		24b. REGISTRAR'S SIGNATURE W. French	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 7 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03577

3620

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN	
TOWN <u>Linthicum</u>		<u>1 yr.</u>		TOWN <u>Linthicum Heights</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>306 Edward Ave.</u>				STREET ADDRESS (If rural give location) <u>306 Edward Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Marie</u> (Middle) <u>Vondriska</u> (Last) <u>Jiricek</u>				(Month) <u>April</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb 2 - 1880</u>		9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Vondriska</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Antoinette Klina</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A) <u>Cardio-Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerosis</u>				10 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/22</u> , 19 <u>56</u> , to <u>4/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/25</u> , 19 <u>56</u> , and that death occurred at <u>7:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Ball Jr.</u>				ADDRESS (Street, city, town, state) <u>M.D. Linthicum</u>		DATE SIGNED <u>4/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		DATE THEREOF <u>4-28-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>BALTO.</u>	
24. REC'D BY REGISTRAR <u>APR 26 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Caldwell Harduff</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Coney</u>		ADDRESS <u>Thurman Home</u>	

CERTIFICATE OF DEATH

3022

1. USUAL RESIDENCE (Name of Decedent)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. PLACE OF BIRTH

8. AGE

9. SEX

10. RACE

11. OCCUPATION

12. EDUCATION

13. MARITAL STATUS

14. RELIGION

15. DATE OF BIRTH

16. PLACE OF BIRTH

17. DATE OF DEATH

18. TIME OF DEATH

19. CAUSE OF DEATH

20. MANNER OF DEATH

21. PLACE OF BIRTH

22. AGE

23. SEX

24. RACE

25. OCCUPATION

26. EDUCATION

27. MARITAL STATUS

28. RELIGION

29. DATE OF BIRTH

30. PLACE OF BIRTH

31. DATE OF DEATH

32. TIME OF DEATH

33. CAUSE OF DEATH

34. MANNER OF DEATH

35. PLACE OF BIRTH

36. AGE

37. SEX

38. RACE

39. OCCUPATION

40. EDUCATION

41. MARITAL STATUS

42. RELIGION

43. DATE OF BIRTH

44. PLACE OF BIRTH

45. DATE OF DEATH

46. TIME OF DEATH

47. CAUSE OF DEATH

48. MANNER OF DEATH

49. PLACE OF BIRTH

50. AGE

51. SEX

52. RACE

53. OCCUPATION

54. EDUCATION

55. MARITAL STATUS

56. RELIGION

57. DATE OF BIRTH

58. PLACE OF BIRTH

59. DATE OF DEATH

60. TIME OF DEATH

61. CAUSE OF DEATH

62. MANNER OF DEATH

63. PLACE OF BIRTH

64. AGE

65. SEX

66. RACE

67. OCCUPATION

68. EDUCATION

69. MARITAL STATUS

70. RELIGION

71. DATE OF BIRTH

72. PLACE OF BIRTH

73. DATE OF DEATH

74. TIME OF DEATH

75. CAUSE OF DEATH

76. MANNER OF DEATH

77. PLACE OF BIRTH

78. AGE

79. SEX

80. RACE

81. OCCUPATION

82. EDUCATION

83. MARITAL STATUS

84. RELIGION

BUREAU V. S.

APR 26 1956

REC'D

[Handwritten signature]

2500 LOST

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE RETURNED TO THE OFFICE OF RECORDS AND STATISTICS, 1001 E. BALTIMORE AVENUE, BALTIMORE, MARYLAND, UPON REQUEST.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03578

3621

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6yrs. 8mos. 19days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Johnson Last Johnson		4. DATE OF DEATH Month April Day 3 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/03
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Booker		14. MOTHER'S MAIDEN NAME Betty Byrd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records - Crownsville State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain atrophy DUE TO (c) Athetosis, dementia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Athetosis, dementia INTERVAL BETWEEN ONSET AND DEATH 3 days Since 1941			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/3 , 19 56 , to 4/3 , 19 56 , that I last saw the deceased alive on 4/3 , 19 56 , and that death occurred at 11:00a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 4/3/56 ACTUAL SIGNATURE L. Benedict, M. D. PHYSICIAN'S NAME (Type) L. Benedict, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/56	
22c. NAME OF CEMETERY OR CREMATORY Balto National		22d. LOCATION (City, town, or county) (State) Balto Md	
23. FUNERAL DIRECTOR'S SIGNATURE Raynor Sanders		24a. REC'D BY REGISTRAR 6 1956	
24b. REGISTRAR'S SIGNATURE Mrs L M Joyce			

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3622 CERTIFICATE OF DEATH

03579

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Arkansas</u>		COUNTY <u>Mississippi</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort G. G. Meade, Md.</u>		LENGTH OF STAY (in this place) <u>3 Months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Osceola</u>		<u>42x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>510 Johnson</u>			
3. NAME OF DECEASED (Type or Print) <u>WALTON</u> (First) <u>EUGENE</u> (Middle) <u>JOHNSON, JR.</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>April 8</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>31 Dec 1927</u>	9. AGE last birthday <u>28</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Army</u>		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walton Eugene Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Laura Driver</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>1948 - 1954</u>		16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT & ADDRESS <u>Wife, Mary Johnson,</u> <u>112 Louise Terrace, Glen Burnie, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerotic heart disease</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8 April</u>, 19<u>56</u>, to <u>8 April</u>, 19<u>56</u>, that I last saw the deceased alive on <u>8 April</u>, 19<u>56</u>, and that death occurred at <u>1945</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert Kurth</u> ROBERT KURTH, CAPT., MC M.D. Fort George G. Meade, Md.				ADDRESS (Street, city, town, state) DATE SIGNED <u>Osceola, ARK.</u> <u>8 April 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Osceola, ARK.</u>		LOCATION (City, town, or county) <u>Osceola, Arkansas</u>	
24. REC'D BY REGISTRAR <u>W.L.SAYDOR, 1ST LT, MSC</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kirley Funeral Home, Glen Burnie, Md.</u>			
DATE <u>10 April 56</u>							

CHAPTER 1

1007-2566-06

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2010

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It is not clear, however, whether the

1

BUREAU V. S.

APR 11 1956

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8053

BUREAU V. S.

APR 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film 195 1-23-56 et

3624

CERTIFICATE OF DEATH

Reg. Dist. No.

03581

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1111 Laurens Street	
3. NAME OF DECEASED (Type or print) First Frances Middle Skinner Last Jones		4. DATE OF DEATH Month 4 Day 7 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1891
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Worker		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Bennie Streams		14. MOTHER'S MAIDEN NAME Miami Streams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital records	
17. INFORMANT Crownsville State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Quadruplegia 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic sub-dural hematoma DUE TO (c) Arteriosclerotic vascular disease INTERVAL BETWEEN ONSET AND DEATH Since 2/8/56 Unknown " "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/28 , 19 56 , to 4/7 , 19 56 , that I last saw the deceased alive on 4/6 , 19 56 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/7/56 PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/12/56	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George S. Nelson		24. REGISTRY REGISTRAR 10 1956	
24b. REGISTRAR'S SIGNATURE E. M. Joyce			

CERTIFICATE OF DEATH

5525

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		40		JAN 15 1915		BALTIMORE		MD		USA			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
LABORER		HEART DISEASE		NATURAL		2 WEEKS		JAN 25 1955		BALTIMORE		MD		USA	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		DATE OF EXAMINATION		NAME OF PHYSICIAN		SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE			
NONE		NONE		NONE		JAN 20 1955		J. H. HARRIS		J. H. HARRIS		JAN 25 1955			
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		DATE OF EXAMINATION		NAME OF PHYSICIAN		SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE			
NONE		NONE		NONE		JAN 20 1955		J. H. HARRIS		J. H. HARRIS		JAN 25 1955			

BUREAU V. 5

APR 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3625

CERTIFICATE OF DEATH

03582

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 BROOKLYN</u>		c. LENGTH OF STAY IN 1b <u>50</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>5301 BALLMAN AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LULA</u> Middle <u>JORDAN</u> Last <u>JORDAN</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>12</u> - Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 20-1880</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>23</u>	
11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE CITY</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE CITY</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>GEORGE SOUTERS</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE METZGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>GEORGE F. JORDAN</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>444X</u> DUE TO <u>cardiac infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension pulmonary edema</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-5</u> , 19 <u>56</u> to <u>4-12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-11</u> , 19 <u>56</u> , and that death occurred at <u>4/12/1956</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene Schmitzer</u> M.D.		ADDRESS (Street, city or town, state) <u>5906 S Hemme</u> DATE SIGNED <u>4/12-56</u>	
PHYSICIAN'S NAME (Type) <u>EUGENE SCHMITZER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-16-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>EASTERN BLVD. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>3500 Bank St.</u>	
24a. REC'D BY REGISTRAR <u>APR 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John J. Connelly</u>	

BUREAU V. S.

APR 16 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3626 CERTIFICATE OF DEATH

03583

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Edgewater</u>		LENGTH OF STAY (in this place) <u>20 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgewater</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>County Home</u>				STREET ADDRESS (If rural give location) <u>County Home</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>STEVE</u> <u>KAPOYLAS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 21</u> <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>? , ? , 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Conduit St.</u> <u>Mr Steve Foundas, Friend, Annapolis, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>592X</u> <u>Haemia</u>						<u>7 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Nephritis</u>						<u>4 mo.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 18, 1956</u> , to <u>April 21, 1956</u> , that I last saw the deceased alive on <u>April 18, 1956</u> , and that death occurred at <u>5</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Maurice Klavans</u>				ADDRESS (Street, city, town, state) <u>Annapolis, Md.</u>		DATE SIGNED <u>4/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 23, 56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>4/23/56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	

BUREAU V. S.

APR 24 1956

RECEIVED

MEDICAL CERTIFICATION

VS. A15ME(5)
5M 9/55

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

03585

2411 N. Charles Street, Baltimore

3628

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH- COUNTY <u>AnneArundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> TOWN <u>Arnold</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shore Acres</u>		MARYLAND LENGTH OF STAY (in this place) <u>10 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u> TOWN <u>Arnold</u> STREET ADDRESS <u>Shore Acres</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>HENRY</u> (First) <u>-</u> (Middle) <u>LONG</u> (Last)		4. DATE OF DEATH <u>April</u> (Month) <u>2</u> (Day) <u>1956</u> (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 30. 1882</u>	9. AGE last birthday <u>73</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>contracting work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Long</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Weis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mr. Wm. J. Sebour - 3917 Hudson Street</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Congestive Heart Failure</u>		<u>??</u>
Antecedent cause(s) (b) <u>Chronic Glomerular Nephritis</u>		<u>??</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>		<u>??</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 12 1956, to March 30 1956, that I last saw the deceased alive on March 30, 1956, and that death occurred at 6: A m., from the causes and on the date stated above.

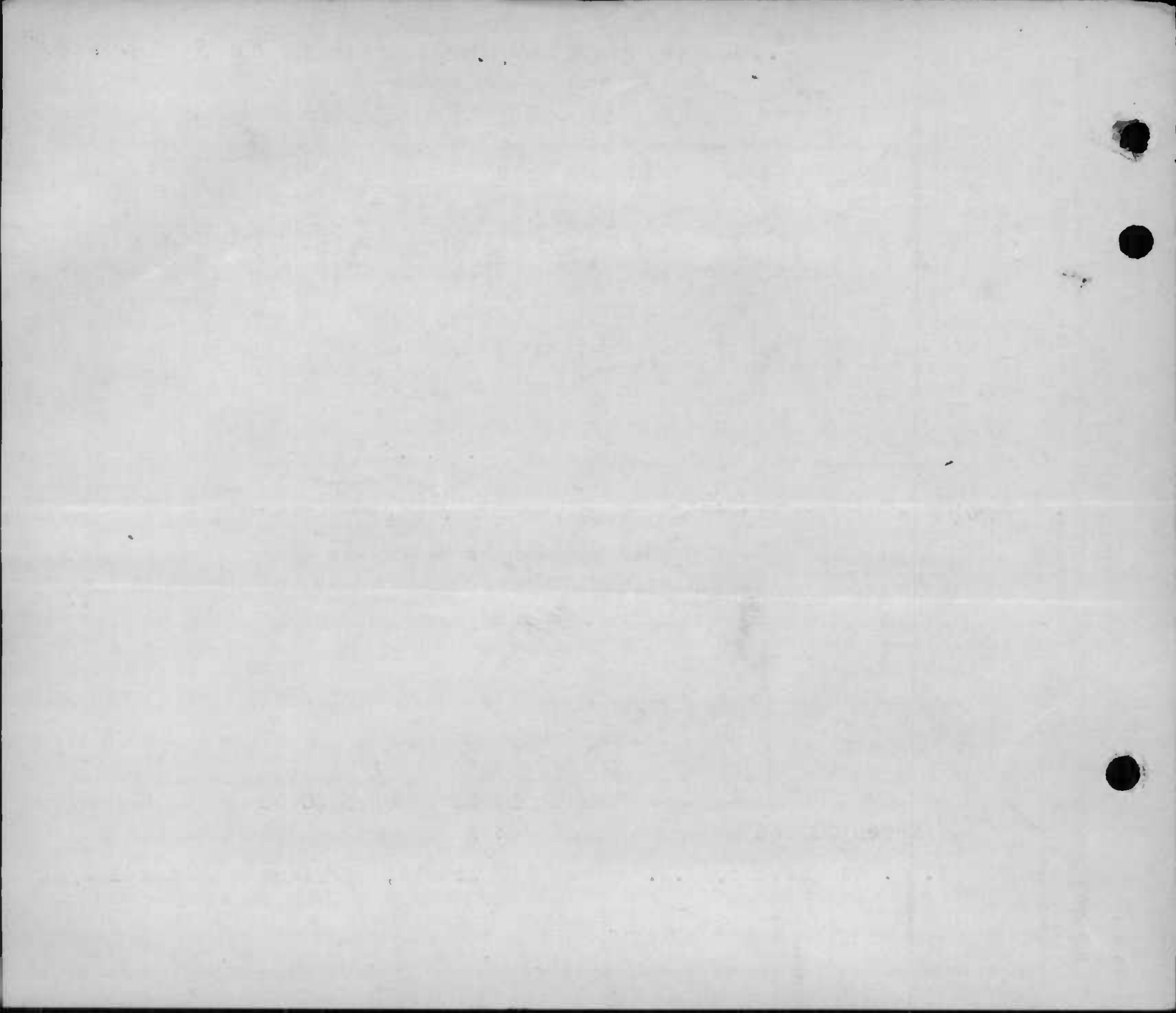
SIGNATURE T. G. de Quevedo, M.D. ADDRESS Arnold, Maryland DATE SIGNED April 3/56

23. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>	DATE THEREOF <u>April 4 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>April 3, 1956</u>	REGISTRAR'S SIGNATURE <u>H. Sander & Sons, Inc.</u>	24. FUNERAL DIRECTOR <u>H. Sander & Sons, Inc.</u> ADDRESS <u>Baltimore, Maryland</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3570

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A. Co., Md</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis General</u>				d. STREET ADDRESS <u>Franklin</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Chester Marshall</u>				4. DATE OF DEATH Month Day Year <u>4 22 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Lizzie ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Agnes Nicholas 817 N. Fremont Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive failure</u> 401.0 DUE TO (b) <u>Pericarditis</u> DUE TO (c) <u>Rheumatic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-22-56</u> , 19 <u>56</u> , to <u>4-22-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-22-56</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ar T. Allen</u> M.D.				ADDRESS (Street, city or town, state) <u>6 L Cathedral St</u> DATE SIGNED <u>4-23-56</u>			
PHYSICIAN'S NAME (Type) <u>ARIS T ALLEN</u>				DATE <u>6 L CATHEDRAL ST</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-26-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isaiah L Brown & Son Montgomery</u>				ADDRESS <u>108 W</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lench</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. DATE OF REGISTRATION		14. TIME OF REGISTRATION		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF REGISTRAR		18. SIGNATURE OF REGISTRAR	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF REGISTRAR		21. SIGNATURE OF REGISTRAR	
22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF REGISTRAR	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF REGISTRAR		27. SIGNATURE OF REGISTRAR	
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97. SIGNATURE OF REGISTRAR		98. SIGNATURE OF REGISTRAR		99. SIGNATURE OF REGISTRAR	
100. SIGNATURE OF REGISTRAR		101. SIGNATURE OF REGISTRAR		102. SIGNATURE OF REGISTRAR	

BUREAU V. S.

APR 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3629

CERTIFICATE OF DEATH

03587

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt.#2, Snow Hill	
3. NAME OF DECEASED (Type or print) First Ida Middle Mae Last Mason		4. DATE OF DEATH Month 4 Day 30 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/23/11
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Edward Taylor		14. MOTHER'S MAIDEN NAME Elizabeth Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Convulsion 016X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Tuberculosis & Hypertensive Encephalopathy DUE TO (c) — — —		INTERVAL BETWEEN ONSET AND DEATH 5 minutes Known since Jan. 1956	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — — — — —	
20c. TIME OF INJURY Month, Day, Year Hour a. — p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/18 , 19 56 , to 4/30 , 19 56 , that I last saw the deceased alive on 4/29 , 19 56 , and that death occurred at 7:40 a.m. from the causes and on the date stated above. ACTUAL SIGNATURE Hildegard Heard Reissmann ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/30/56			
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/3/56	
22c. NAME OF CEMETERY OR CREMATORY Taylor State		22d. LOCATION (City, town, or county) (State) Snow Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Jones		24a. REC'D BY REGISTRAR 5/3/56	
ADDRESS Snow Hill, Md.		24b. REGISTRAR'S SIGNATURE L. M. Jones	

33

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The original or attending physician may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3630

CERTIFICATE OF DEATH

Reg. Dist. No.

03588
28

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hosp.		d. STREET ADDRESS 1936 W. Lexington St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank McEachin		4. DATE OF DEATH Month Day Year April 28 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH ?
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY N.C.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jack McEachin		14. MOTHER'S MAIDEN NAME Flora ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Hospital records	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia DUE TO (c) undet. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pt had herniorrhaphy on 4-12-56			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 18, 1956 to April 28, 56 , that I last saw the deceased alive on 4/28/56 , and that death occurred at 8:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. Annapolis DATE SIGNED Maryland			
ACTUAL SIGNATURE Conwell Newton		M.D. Conwell Newton, MD.	
PHYSICIAN'S NAME (Type) Conwell Newton, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried May 2-56		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Wilson Chapel Cemetery		22d. LOCATION (City, town, or county) (State) N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Williams		24a. REC'D BY REGISTRAR 5/3/56	
ADDRESS 1703 N. Bond St		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 8
MAY 4 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3631

CERTIFICATE OF DEATH

03589

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Millersville		6 weeks		TOWN Glen Burnie			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sanns Nursing Home				STREET ADDRESS (If rural give location) 506 Theresa Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Mary Emma McLane				April 17 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Widowed	Nov. 16, 1877	78 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Own Home		Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Nathan Longest				Margaret Jeffries			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		213 - 01 - 9424 B Carl W. McLane, Glen Burnie, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						2 y.	
447 X IMMEDIATE CAUSE (A) Hypertensive Vascular Diseases							
DUE TO ANTECEDENT CAUSE(S) (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from February 44, to April 17, 56, that I last saw the deceased alive on 4/16/56, 19, and that death occurred at 4 P.M. from the causes and on the date stated above.							
SIGNATURE Eusebio K. Pacheco				ADDRESS (Street, city, town, state) M.D. Glen Burnie, Md.		DATE SIGNED 4/18/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4/20/56		Glen Haven Memorial		Glen Burnie, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE APR 23 1956		A. M. Joyce		James S. Kirkley		Glen Burnie, Md.	

CERTIFICATE OF DEATH

Form No. 10

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. SEX

6. AGE

7. OCCUPATION OF DECEASED

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEAREST RELATIVE

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF DISTRICT ATTORNEY

20. SIGNATURE OF COUNTY CLERK

21. SIGNATURE OF TOWNSHIP CLERK

22. SIGNATURE OF VOTING CLERK

23. SIGNATURE OF POLLING CLERK

24. SIGNATURE OF JURY CLERK

25. SIGNATURE OF COURT CLERK

26. SIGNATURE OF CLERK OF SUPERIOR COURT

27. SIGNATURE OF CLERK OF DISTRICT COURT

28. SIGNATURE OF CLERK OF COUNTY COURT

29. SIGNATURE OF CLERK OF TOWNSHIP COURT

30. SIGNATURE OF CLERK OF VOTING PLACE

31. SIGNATURE OF CLERK OF POLLING PLACE

32. SIGNATURE OF CLERK OF JURY BOX

33. SIGNATURE OF CLERK OF COURT HOUSE

34. SIGNATURE OF CLERK OF PRISON

35. SIGNATURE OF CLERK OF ASYLUM

36. SIGNATURE OF CLERK OF HOSPITAL

37. SIGNATURE OF CLERK OF CHURCH

38. SIGNATURE OF CLERK OF SCHOOL

39. SIGNATURE OF CLERK OF POST OFFICE

40. SIGNATURE OF CLERK OF TOWN

41. SIGNATURE OF CLERK OF COUNTY

42. SIGNATURE OF CLERK OF STATE

43. SIGNATURE OF CLERK OF NATION

44. SIGNATURE OF CLERK OF WORLD

45. SIGNATURE OF CLERK OF UNIVERSE

46. SIGNATURE OF CLERK OF GOD

47. SIGNATURE OF CLERK OF HEAVEN

48. SIGNATURE OF CLERK OF EARTH

49. SIGNATURE OF CLERK OF FIRE

50. SIGNATURE OF CLERK OF WATER

51. SIGNATURE OF CLERK OF AIR

52. SIGNATURE OF CLERK OF SOIL

53. SIGNATURE OF CLERK OF ROCK

54. SIGNATURE OF CLERK OF MOUNTAIN

55. SIGNATURE OF CLERK OF VALLEY

56. SIGNATURE OF CLERK OF PLAIN

57. SIGNATURE OF CLERK OF HILL

58. SIGNATURE OF CLERK OF CANYON

59. SIGNATURE OF CLERK OF MOUNTAIN

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137. SIGNATURE OF CLERK OF HILL

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151. SIGNATURE OF CLERK OF PLAIN

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156. SIGNATURE OF CLERK OF PLAIN

157. SIGNATURE OF CLERK OF HILL

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163. SIGNATURE OF CLERK OF CANYON

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165. SIGNATURE OF CLERK OF VALLEY

166. SIGNATURE OF CLERK OF PLAIN

167. SIGNATURE OF CLERK OF HILL

168. SIGNATURE OF CLERK OF CANYON

169. SIGNATURE OF CLERK OF MOUNTAIN

170. SIGNATURE OF CLERK OF VALLEY

171. SIGNATURE OF CLERK OF PLAIN

172. SIGNATURE OF CLERK OF HILL

173. SIGNATURE OF CLERK OF CANYON

174. SIGNATURE OF CLERK OF MOUNTAIN

175. SIGNATURE OF CLERK OF VALLEY

176. SIGNATURE OF CLERK OF PLAIN

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180. SIGNATURE OF CLERK OF VALLEY

181. SIGNATURE OF CLERK OF PLAIN

182. SIGNATURE OF CLERK OF HILL

183. SIGNATURE OF CLERK OF CANYON

184. SIGNATURE OF CLERK OF MOUNTAIN

185. SIGNATURE OF CLERK OF VALLEY

186. SIGNATURE OF CLERK OF PLAIN

187. SIGNATURE OF CLERK OF HILL

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189. SIGNATURE OF CLERK OF MOUNTAIN

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191. SIGNATURE OF CLERK OF PLAIN

192. SIGNATURE OF CLERK OF HILL

193. SIGNATURE OF CLERK OF CANYON

194. SIGNATURE OF CLERK OF MOUNTAIN

195. SIGNATURE OF CLERK OF VALLEY

196. SIGNATURE OF CLERK OF PLAIN

197. SIGNATURE OF CLERK OF HILL

198. SIGNATURE OF CLERK OF CANYON

199. SIGNATURE OF CLERK OF MOUNTAIN

200. SIGNATURE OF CLERK OF VALLEY

201. SIGNATURE OF CLERK OF PLAIN

202. SIGNATURE OF CLERK OF HILL

BUREAU V. S.

APR 23 1956

RECEIVED

3571

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>C. F. General</u>				d. STREET ADDRESS <u>248 Prince Geo St.</u>			
3. NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>E.</u> Last <u>MEDFORD</u>				4. DATE OF DEATH Month <u>4-</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 21-1897</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Harbor Master</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Annapolis</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>William E. Medford</u>			
14. MOTHER'S MAIDEN NAME <u>Medora Chambers</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>			
16. SOCIAL SECURITY NO. <u>1-1-1-1-1-1-1-1-1-1</u>				17. INFORMANT <u>Eva Q. Medford</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>20 March, 1956</u> , to <u>25 April, 1956</u> , that I last saw the deceased alive on <u>25 April, 1956</u> , and that death occurred at <u>3:00 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward Beck</u> M.D. <u>H. Southgate Ave Annapolis</u>				DATE SIGNED <u>4/26/56</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Annes</u>		22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md.</u>				24a. REC'D BY REGISTRAR DATE <u>4-30-1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. - J. J. J.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1921		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
MAY 2 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		GUNSHOT WOUNDS		DR. JAMES H. HARRIS	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		PREVIOUS ILLNESS		HISTORY OF DRUGS	
CONTRACTOR		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE	
DATE OF INTERVIEW		INTERVIEWER		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MEDICAL ATTENDANT		SIGNATURE OF REGISTRAR	
MAY 2 1968		JAMES H. HARRIS		JAMES EARL RAY		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

BUREAU V. 5

MAY 2 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03591

3572

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u> MARYLAND				STATE <u>md.</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. General Hosp.</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Baby</u> <u>Medley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>34-14</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>4-13-56</u>	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, md.</u>		
13. FATHER'S NAME <u>James Proctor</u>			14. MOTHER'S MAIDEN NAME <u>Edlyn Medley</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unk.) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S ADDRESS <u>Hosp. Records</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
763.5 IMMEDIATE CAUSE (A) <u>Pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>4-13-56</u> <u>7</u> <u>1956</u> , to <u>4-13-56</u> , that I last saw the deceased alive on <u>4-13-56</u> , 19 <u>5</u> and that death occurred at <u>5</u> P.M. , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>			ADDRESS (Street, city, town, state) <u>61 Cottage</u>		DATE SIGNED <u>4-18-56</u>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-15-56</u>	NAME OF CEMETERY OR CREMATORY <u>Crown</u>		LOCATION (City, town, or county) (State) <u>Galesville, md.</u>		
24. REC'D BY REGISTRAR <u>APR 17 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME: *John C. C.*
 RESIDENCE: *Chesapeake*

DECEASED: *John C. C.*
 PLACE OF DEATH: *Chesapeake*

DATE OF DEATH: *3-14-25*

AGE: *3-14-25*

SEX: *Male*

CAUSE OF DEATH: *Chesapeake*
John C. C.

PLACE OF DEATH: *Chesapeake*
John C. C.

BUREAU V. S.

APR 12 1956

RECEIVED
 BALTIMORE, MD.

3-12-25

John C. C.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03592

3632

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Same</u>		COUNTY <u>Same</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>P.O. Glen Burnie</u>		LENGTH OF STAY (in this place) <u>14 y.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Same</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Point Pleasant</u>				STREET ADDRESS (If rural give location) <u>Same</u>			
3. NAME OF DECEASED (Type or Print) <u>William Russell Metzger</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 1st 19 56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/25/96</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road Com.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Metzger</u>				14. MOTHER'S MAIDEN NAME <u>Mary Fosdrink</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-9410</u>		17. INFORMANT & ADDRESS <u>Mrs. Marie Metzger (Wife).</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Hypertensive Cardio Vascular Diseases.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 years.</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>52</u> , to <u>4/1/56</u> , 19....., that I last saw the deceased alive on <u>4/30/56</u> , 19....., and that death occurred at <u>6.45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Christina K. Rautenbach</u>				ADDRESS (Street, city, town, state) <u>M.D. Glen Burnie, Md.</u>		DATE SIGNED <u>4/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 4, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>April 3, 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>	

CERTIFICATE OF DEATH

1930

Reg. Dist. No.

1. FULL RESIDENCE ADDRESS OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. DATE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF JUDGE

19. SIGNATURE OF CLERK

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF SHERIFF'S DEPUTY

23. SIGNATURE OF SHERIFF'S CLERK

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BUREAU V. S.

APR 5 1930

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03593

3573 **CERTIFICATE OF DEATH**Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Maryland</u> COUNTY <u>St. Georges</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Rainier</u>		OR TOWN <u>16-16-2</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>9 DAYS</u>		STREET ADDRESS (If rural give location) <u>2704 Allison Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convalescent Home</u>							
3. NAME OF DECEASED (First) <u>MAY</u> (Middle) <u>W.</u> (Last) <u>MILLER</u>				4. DATE OF DEATH (Month) <u>4</u> (Day) <u>13</u> (Year) <u>1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Dec. 16, 1866</u>	
9. AGE last birthday <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. a</u>	
13. FATHER'S NAME <u>Thomas Woodburn</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Chamberlain</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Ms. Floyd Rapp</u>		18. MEDICAL CERTIFICATION		19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		21. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		22. I hereby certify that I attended the deceased from <u>4 APR.</u> , 19 <u>56</u> , to <u>13 APR.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>13 APR.</u> , 19 <u>56</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above.	
IMMEDIATE CAUSE (A) <u>Uremia</u>		ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>		21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. DATE OF OPERATION		21g. MAJOR FINDINGS OF OPERATION		21h. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21i. HOW DID INJURY OCCUR?	
21j. DATE OF OPERATION		21k. MAJOR FINDINGS OF OPERATION		21l. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21m. HOW DID INJURY OCCUR?	
21n. DATE OF OPERATION		21o. MAJOR FINDINGS OF OPERATION		21p. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21q. HOW DID INJURY OCCUR?	
21r. DATE OF OPERATION		21s. MAJOR FINDINGS OF OPERATION		21t. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21u. HOW DID INJURY OCCUR?	
21v. DATE OF OPERATION		21w. MAJOR FINDINGS OF OPERATION		21x. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21y. HOW DID INJURY OCCUR?	
21z. DATE OF OPERATION		21aa. MAJOR FINDINGS OF OPERATION		21ab. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ac. HOW DID INJURY OCCUR?	
21ad. DATE OF OPERATION		21ae. MAJOR FINDINGS OF OPERATION		21af. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ag. HOW DID INJURY OCCUR?	
21ah. DATE OF OPERATION		21ai. MAJOR FINDINGS OF OPERATION		21aj. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ak. HOW DID INJURY OCCUR?	
21al. DATE OF OPERATION		21am. MAJOR FINDINGS OF OPERATION		21an. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ao. HOW DID INJURY OCCUR?	
21ap. DATE OF OPERATION		21aq. MAJOR FINDINGS OF OPERATION		21ar. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21as. HOW DID INJURY OCCUR?	
21at. DATE OF OPERATION		21au. MAJOR FINDINGS OF OPERATION		21av. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21aw. HOW DID INJURY OCCUR?	
21ax. DATE OF OPERATION		21ay. MAJOR FINDINGS OF OPERATION		21az. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ba. HOW DID INJURY OCCUR?	
21bc. DATE OF OPERATION		21bd. MAJOR FINDINGS OF OPERATION		21be. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21bf. HOW DID INJURY OCCUR?	
21bg. DATE OF OPERATION		21bh. MAJOR FINDINGS OF OPERATION		21bi. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21bj. HOW DID INJURY OCCUR?	
21bk. DATE OF OPERATION		21bl. MAJOR FINDINGS OF OPERATION		21bm. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21bn. HOW DID INJURY OCCUR?	
21bo. DATE OF OPERATION		21bp. MAJOR FINDINGS OF OPERATION		21bq. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21br. HOW DID INJURY OCCUR?	
21bs. DATE OF OPERATION		21bt. MAJOR FINDINGS OF OPERATION		21bu. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21bv. HOW DID INJURY OCCUR?	
21bw. DATE OF OPERATION		21bx. MAJOR FINDINGS OF OPERATION		21by. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21bz. HOW DID INJURY OCCUR?	
21ca. DATE OF OPERATION		21cb. MAJOR FINDINGS OF OPERATION		21cc. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21cd. HOW DID INJURY OCCUR?	
21ce. DATE OF OPERATION		21cf. MAJOR FINDINGS OF OPERATION		21cg. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ch. HOW DID INJURY OCCUR?	
21ci. DATE OF OPERATION		21cj. MAJOR FINDINGS OF OPERATION		21ck. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21cl. HOW DID INJURY OCCUR?	
21cm. DATE OF OPERATION		21cn. MAJOR FINDINGS OF OPERATION		21co. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21cp. HOW DID INJURY OCCUR?	
21cq. DATE OF OPERATION		21cr. MAJOR FINDINGS OF OPERATION		21cs. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ct. HOW DID INJURY OCCUR?	
21cu. DATE OF OPERATION		21cv. MAJOR FINDINGS OF OPERATION		21cw. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21cx. HOW DID INJURY OCCUR?	
21cy. DATE OF OPERATION		21cz. MAJOR FINDINGS OF OPERATION		21da. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21db. HOW DID INJURY OCCUR?	
21dc. DATE OF OPERATION		21dd. MAJOR FINDINGS OF OPERATION		21de. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21df. HOW DID INJURY OCCUR?	
21dg. DATE OF OPERATION		21dh. MAJOR FINDINGS OF OPERATION		21di. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21dj. HOW DID INJURY OCCUR?	
21dk. DATE OF OPERATION		21dl. MAJOR FINDINGS OF OPERATION		21dm. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21dn. HOW DID INJURY OCCUR?	
21do. DATE OF OPERATION		21dp. MAJOR FINDINGS OF OPERATION		21dq. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21dr. HOW DID INJURY OCCUR?	
21ds. DATE OF OPERATION		21dt. MAJOR FINDINGS OF OPERATION		21du. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21dv. HOW DID INJURY OCCUR?	
21dw. DATE OF OPERATION		21dx. MAJOR FINDINGS OF OPERATION		21dy. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21dz. HOW DID INJURY OCCUR?	
21ea. DATE OF OPERATION		21eb. MAJOR FINDINGS OF OPERATION		21ec. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ed. HOW DID INJURY OCCUR?	
21ee. DATE OF OPERATION		21ef. MAJOR FINDINGS OF OPERATION		21eg. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21eh. HOW DID INJURY OCCUR?	
21ei. DATE OF OPERATION		21ej. MAJOR FINDINGS OF OPERATION		21ek. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21el. HOW DID INJURY OCCUR?	
21em. DATE OF OPERATION		21en. MAJOR FINDINGS OF OPERATION		21eo. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ep. HOW DID INJURY OCCUR?	
21eq. DATE OF OPERATION		21er. MAJOR FINDINGS OF OPERATION		21es. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21et. HOW DID INJURY OCCUR?	
21eu. DATE OF OPERATION		21ev. MAJOR FINDINGS OF OPERATION		21ew. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ex. HOW DID INJURY OCCUR?	
21ey. DATE OF OPERATION		21ez. MAJOR FINDINGS OF OPERATION		21fa. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21fb. HOW DID INJURY OCCUR?	
21fc. DATE OF OPERATION		21fd. MAJOR FINDINGS OF OPERATION		21fe. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21fg. DATE OF OPERATION		21fh. MAJOR FINDINGS OF OPERATION		21fi. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21fk. DATE OF OPERATION		21fl. MAJOR FINDINGS OF OPERATION		21fo. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21fm. DATE OF OPERATION		21fn. MAJOR FINDINGS OF OPERATION		21fp. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21fq. DATE OF OPERATION		21fr. MAJOR FINDINGS OF OPERATION		21fs. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ft. DATE OF OPERATION		21fu. MAJOR FINDINGS OF OPERATION		21fv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21fw. DATE OF OPERATION		21fx. MAJOR FINDINGS OF OPERATION		21fv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21fy. DATE OF OPERATION		21fz. MAJOR FINDINGS OF OPERATION		21fw. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ga. DATE OF OPERATION		21gb. MAJOR FINDINGS OF OPERATION		21gx. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gc. DATE OF OPERATION		21gd. MAJOR FINDINGS OF OPERATION		21gy. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ge. DATE OF OPERATION		21gf. MAJOR FINDINGS OF OPERATION		21gz. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gg. DATE OF OPERATION		21gh. MAJOR FINDINGS OF OPERATION		21ha. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gi. DATE OF OPERATION		21gk. MAJOR FINDINGS OF OPERATION		21hb. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gl. DATE OF OPERATION		21gm. MAJOR FINDINGS OF OPERATION		21hc. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gn. DATE OF OPERATION		21go. MAJOR FINDINGS OF OPERATION		21hd. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gp. DATE OF OPERATION		21gq. MAJOR FINDINGS OF OPERATION		21he. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gr. DATE OF OPERATION		21gs. MAJOR FINDINGS OF OPERATION		21hf. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gt. DATE OF OPERATION		21gv. MAJOR FINDINGS OF OPERATION		21hg. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gu. DATE OF OPERATION		21gw. MAJOR FINDINGS OF OPERATION		21hh. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gv. DATE OF OPERATION		21gx. MAJOR FINDINGS OF OPERATION		21hi. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21gz. DATE OF OPERATION		21gy. MAJOR FINDINGS OF OPERATION		21hj. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ha. DATE OF OPERATION		21hz. MAJOR FINDINGS OF OPERATION		21ik. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hb. DATE OF OPERATION		21ia. MAJOR FINDINGS OF OPERATION		21il. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hc. DATE OF OPERATION		21ib. MAJOR FINDINGS OF OPERATION		21im. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hd. DATE OF OPERATION		21ic. MAJOR FINDINGS OF OPERATION		21in. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21he. DATE OF OPERATION		21id. MAJOR FINDINGS OF OPERATION		21io. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hf. DATE OF OPERATION		21ie. MAJOR FINDINGS OF OPERATION		21ip. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hg. DATE OF OPERATION		21if. MAJOR FINDINGS OF OPERATION		21iq. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hh. DATE OF OPERATION		21ig. MAJOR FINDINGS OF OPERATION		21ir. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hi. DATE OF OPERATION		21ih. MAJOR FINDINGS OF OPERATION		21is. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hj. DATE OF OPERATION		21ii. MAJOR FINDINGS OF OPERATION		21it. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hk. DATE OF OPERATION		21ij. MAJOR FINDINGS OF OPERATION		21iu. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hl. DATE OF OPERATION		21ik. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hm. DATE OF OPERATION		21il. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hn. DATE OF OPERATION		21im. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ho. DATE OF OPERATION		21in. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hp. DATE OF OPERATION		21io. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hq. DATE OF OPERATION		21ip. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hr. DATE OF OPERATION		21iq. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hs. DATE OF OPERATION		21ir. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ht. DATE OF OPERATION		21is. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hu. DATE OF OPERATION		21it. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21hv. DATE OF OPERATION		21iu. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ia. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ib. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ic. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21id. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ie. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21if. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ig. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ih. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ii. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ij. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21ik. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCCUR?	
21il. DATE OF OPERATION		21iv. MAJOR FINDINGS OF OPERATION		21iv. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21ff. HOW DID INJURY OCC	

BUREAU V. S.

APR 17 1958

REGISTRATION

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

3633

CERTIFICATE OF DEATH

03594

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Millersville</u>		<u>33 days</u>		TOWN <u>Severn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary</u> <u>Moon</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 3 rd.</u> <u>19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>3/1/64</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Sann's Nursing Home Records.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH
191X IMMEDIATE CAUSE (A) <u>General Arteriosclerosis</u>							<u>?</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cancer of the skin (generalized)</u>							<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/1/56</u> , 19....., to <u>4/3/56</u> , 19....., that I last saw the deceased alive on <u>4/1/56</u> , 19....., and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gustaf H. Paubert</u>				M.D. <u>Glen Burnie, Md.</u> <u>4/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>April 5/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	
24. REC'D BY REGISTRAR <u>APR 5 1956</u>				REGISTRAR'S SIGNATURE <u>A. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H. J. ...</u> ADDRESS <u>Glen Burnie Md.</u>	

CERTIFICATE OF DEATH

THE DEPT. OF HEALTH

IN THE DEPARTMENT OF HEALTH

STATE OF MARYLAND

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

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BUREAU V. S.

APR 5 1936

RECEIVED

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STATE OF MARYLAND

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8, Film G197 5-14-56 et

03595

3574

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Annapolis</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Annapolis</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>40 Calvert St</i>				STREET ADDRESS (If rural give location) <i>40 Calvert St</i>			
3. NAME OF DECEASED (Type or Print) <i>Susie Parker</i>				4. DATE OF DEATH (Month) <i>4</i> (Day) <i>29</i> (Year) <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W.</i>	8. DATE OF BIRTH <i>1883 3-2-1883</i>	9. AGE last birthday <i>73</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Calvert Co. - Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Young</i>				14. MOTHER'S MAIDEN NAME <i>Emily Smith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mrs. Sadie Thompson 34 Calvert St.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>420.1</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-21</i> , 19 <i>56</i> , to <i>4-29</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4-25</i> , 19 <i>56</i> , and that death occurred at <i>4:15</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state)		DATE SIGNED <i>4-30-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-2-56</i>		NAME OF CEMETERY OR CREMATORY <i>Adams Chapel</i>		LOCATION (City, town, or county) (State) <i>Bayard Md</i>	
24. REC'D BY REGISTRAR DATE <i>5-7-1956</i>		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese II</i>		ADDRESS <i>Annapolis, Md</i>	

PHOTOGRAPH

1. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

2. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

3. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

4. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

5. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

6. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

7. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

8. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

9. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

10. This is to certify that the above is a true and correct copy of the photograph of the deceased as taken by the photographer named in the certificate of death.

CERTIFICATE OF DEATH

ANNEXED STATE OF ARKANSAS OF HEALTH-BALTIMORE 18

3571

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. CAUSE OF DEATH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF TOWN CLERK

20. SIGNATURE OF VILLAGE CLERK

21. SIGNATURE OF CITY CLERK

22. SIGNATURE OF STATE CLERK

23. SIGNATURE OF NATIONAL CLERK

24. SIGNATURE OF INTERNATIONAL CLERK

25. SIGNATURE OF UNIVERSAL CLERK

26. SIGNATURE OF COSMOPOLITAN CLERK

27. SIGNATURE OF PAN-ETHNIC CLERK

28. SIGNATURE OF PAN-RACIAL CLERK

29. SIGNATURE OF PAN-RELIGIOUS CLERK

30. SIGNATURE OF PAN-NATIONAL CLERK

31. SIGNATURE OF PAN-CONTINENTAL CLERK

32. SIGNATURE OF PAN-EMPIRE CLERK

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225. SIGNATURE OF PAN-HEAVEN CLERK

226. SIGNATURE OF PAN-EARTH CLERK

227. SIGNATURE OF PAN-SEA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3634
CERTIFICATE OF DEATH

03596

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
c. LENGTH OF STAY IN 1b 69 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 712 Greenmount Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Parramore Last Parramore		4. DATE OF DEATH Month 4 Day 24 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known		10b. KIND OF BUSINESS OR INDUSTRY — — —	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Parramore		14. MOTHER'S MAIDEN NAME Ada ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AHCVD (Arteriosclerotic Hypertensive Cardio-vascular Disease) DUE TO (c) Known since 11/1955 Known since 1941			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/15 , 19 56 , to 4/24 , 19 56 , that I last saw the deceased alive on 4/24/56 , and that death occurred at 10:45 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Heard Reissmann		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/24/56	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann			
22a. BURIAL, CREMATION, REMOVAL (Specify) 4/28/56		22b. DATE THEREOF 4/28/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Randolph B. Ollick ADDRESS 1412 E. Preston St.		24a. RECEIVED BY REGISTRAR APR 27 1956 24b. REGISTRAR'S SIGNATURE X. M. Joyce	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

MAY 1 1955

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the funeral director. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Pasadena</u>		c. LENGTH OF STAY IN 1b <u>11 Months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Forest Glen</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Walter Lewis Payne</u>			4. DATE OF DEATH Month <u>April</u> Day <u>20th</u> Year <u>19 56</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/66</u>		9. AGE (In years last birthday) <u>89</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Becht Co.</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas R. Payne</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Hayes</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-8055A</u>	17. INFORMANT Address <u>Pasadena, Md</u> <u>Mrs. Virginia Bricker (daughter)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> DUE TO (c) <u>?</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Apr. 24/56 Western</u>			22b. DATE THEREOF <u>Apr. 24/56</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Md</u>			22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witke</u>			24a. REC'D BY REGISTRAR <u>DATE APR 23 1956</u>		
24b. REGISTRAR'S SIGNATURE <u>L. J. Adkins</u>			24c. DATE <u>4/20/56</u>		

3055 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		HOURS OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT	
HISTORY OF DEATH		PREVIOUS ILLNESS		HABITS		OCCUPATION		FAMILY HISTORY	
SIGNATURE OF EXAMINER		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF WITNESS		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF CORONER		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF JURY		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF JUDGE		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF CLERK		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF SHERIFF		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF DEPUTY SHERIFF		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF CONSTABLE		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF JURY		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF JUDGE		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF CLERK		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF SHERIFF		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF DEPUTY SHERIFF		TITLE		ADDRESS		CITY		STATE	
SIGNATURE OF CONSTABLE		TITLE		ADDRESS		CITY		STATE	

BUREAU V. S.

APR 24 1956

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3636

CERTIFICATE OF DEATH

03598

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>17A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Falesville</u>		c. LENGTH OF STAY IN 1b <u>48 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falesville</u>		d. STREET ADDRESS <u>100</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND DELEHAY PEARKE</u>		4. DATE OF DEATH Month Day Year <u>April 8 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 29 1883</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House</u>	
11. BIRTHPLACE (State or foreign country) <u>West River Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>J. Millard Pearke</u>		14. MOTHER'S MAIDEN NAME <u>LEMMMA COLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218018623</u>	
17. INFORMANT <u>EDITH LE PEARKE Falesville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gen. carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma of prostate</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 55</u> , 19 <u>55</u> , to <u>Apr. 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr. 6</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Amos Garrett Blvd., Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>S. Borasuck, M.D.</u>		DATE SIGNED <u>4/9/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 10/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>2nd R.R.</u>		22d. LOCATION (City, town, or county) (State) <u>Falesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Falesville Md.</u>	
24a. REC'D BY REGISTRAR <u>4-13-56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

APR 16 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3575 CERTIFICATE OF DEATH

03599

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>1 day</u>		TOWN <u>Davidsonville Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>a & General</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Thomas Albert Pindell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 18 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 4 1895</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tobacco</u>		11. BIRTHPLACE (State or foreign country) <u>Davidsonville Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Thomas D. Pindell</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Rawlings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>213 22 0924</u>		17. INFORMANT & ADDRESS <u>Emma Holland Davidsonville Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
434.1 IMMEDIATE CAUSE (A) <u>acute congestive failure</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-4-55</u> , 19 <u>55</u> , to <u>4-18-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-18-56</u> , 19 <u>56</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. T. Allen</u>		M.D. <u>62 Crutcher St</u>		ADDRESS (Street, city, town, state) <u>Davidsonville Md.</u>		DATE SIGNED <u>4-21-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 20/56</u>		NAME OF CEMETERY OR CREMATORY <u>Union Methodist</u>		LOCATION (City, town, or county) (State) <u>Davidsonville Md.</u>	
24. REC'D BY REGISTRAR <u>JO</u>		REGISTRAR'S SIGNATURE <u>J. T. Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hardy</u>		ADDRESS <u>Salisbury Md.</u>	
DATE <u>May 2, 1956</u>							

CERTIFICATE OF DEATH

1955

1. FULL NAME OF DECEASED

THOMAS ALBERT PRIDE
BORN 1895

DECEASED
THOMAS ALBERT PRIDE
BORN 1895

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CLERK

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CLERK

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

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277. SIGNATURE OF JUDGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film G196 1-20-56 et

3637

CERTIFICATE OF DEATH

Reg. Dist. No.

03600

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co. MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 First Street</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale A.A. Co.</u>	
		d. STREET ADDRESS <u>107-1st Ave.</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>L.</u> Last <u>Pitts</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9/1891</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Louis Pitts</u>		14. MOTHER'S MAIDEN NAME <u>Julia Joyce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>212-09-2714</u>	
17. INFORMANT <u>Mrs. Catherine Thayer</u>		Address <u>107-1st Ave Ferndale</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Sept. 1955</u> to <u>April 1, 1956</u> , that I last saw the deceased alive on <u>April 14, 1956</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>H. D. Franklin</u> M.D.			
PHYSICIAN'S NAME (Type) <u>H. D. Franklin</u> <u>1123 St. Paul St Baltimore Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herwig Son</u>		24a. REC'D BY REGISTRAR <u>2024</u>	
24b. REGISTRAR'S SIGNATURE <u>L. J. Adkins</u>		DATE <u>APR 17 1956</u>	

1228

BUREAU V. 3

APR 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3576

CERTIFICATE OF DEATH

Reg. Dist. No. 21

03601

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		d. STREET ADDRESS <u>48 Southgate Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>48 Southgate Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>REICHEL</u> Last <u>DDS</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 14, 1899</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Practice</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hyman Reichel</u>		14. MOTHER'S MAIDEN NAME <u>Lena Reichel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Jesse E. Reichel - Wife - same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Thrs.</u> <u>6 mrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 8, 1956</u> , to <u>April 25, 1956</u> , that I last saw the deceased alive on <u>April 25, 1956</u> , and that death occurred at <u>7:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		DATE SIGNED <u>Annapolis, Md 4/25/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Maurice F. Klawans</u>		<u>31 Southgate Ave. Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 26, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Kneseth Israel Semetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>4-25-56</u>		<u> </u>	

CERTIFICATE OF DEATH

3570

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1956

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. DATE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>10. SIGNATURE OF REGISTRAR [Illegible]</p>	
<p>11. SIGNATURE OF DECEASED [Illegible]</p>		<p>12. SIGNATURE OF WITNESSES [Illegible]</p>	
<p>13. SIGNATURE OF FUNERAL HOME [Illegible]</p>		<p>14. SIGNATURE OF BURIAL PLACE [Illegible]</p>	
<p>15. SIGNATURE OF VENDOR [Illegible]</p>		<p>16. SIGNATURE OF OTHER [Illegible]</p>	

BUREAU Y. 1

APR 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the funeral or attending physician. The law requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3577

CERTIFICATE OF DEATH

Reg. Dist. 036024

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>5 MARYLAND AVE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATHRYN BARRICK RICE</u>		4. DATE OF DEATH Month Day Year <u>APRIL 15 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/1906</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LEONARD BARRICK</u>		14. MOTHER'S MAIDEN NAME <u>MAMIE SPAHR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address <u>LC. BARRICK, WOODSBORO, M.D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastatic Carcinoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Appendix</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-25-53</u> <u>4-15-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-28</u> , 19 <u>56</u> , to <u>4-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-14-56</u> , 19 <u>56</u> , and that death occurred at <u>5:10</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler M.D.</u>		ADDRESS (Street, city or town, state) <u>45 Franklin St. Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>		DATE SIGNED <u>4-15-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT. HOPE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WOODSBORO, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>POWELL & HARTZLER</u>		ADDRESS <u>WOODSBORO, MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>Wm. J. French</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	
DATE <u>18 1956</u>			

3638

CERTIFICATE OF DEATH

Item 6, Film GL96 5-2-56 et

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Glen Burnie		LENGTH OF STAY (in this place) 2 1/2 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Harundale, Glen Burnie			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1027 Upton Road				STREET ADDRESS (If rural give location) 1027 Upton Road			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Gerald Rosenberg				4. DATE OF DEATH (Month) (Day) (Year) April 21, 1956			
5. SEX Male	6. COLOR OR RACE White Jewish	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH November 16, 1905	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ordinance Inspector		10b. KIND OF BUSINESS OR INDUSTRY US Gov't.		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Rosenberg				14. MOTHER'S MAIDEN NAME Anna Kreisman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 1925 - 1930		17. INFORMANT & ADDRESS Mrs M. E. Rosenberg,		same as 2	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157x IMMEDIATE CAUSE (A) GASTRO-INTESTINAL HEMORRHAGE						3 DAYS.	
ANTECEDENT CAUSE(S) DUE TO (B) CANCER OF PANCREAS METAST. TO LIVER						8 MOS.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-6, 1955, to 4-21, 1956, that I last saw the deceased alive on 4-21, 1956, and that death occurred at 9:10 P.M. from the causes and on the date stated above.							
SIGNATURE Leon C. Perry				ADDRESS (Street, city, town, state) 2013 + A Blvd, Glen Burnie, MD		DATE SIGNED 4-23-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial & Rem.		DATE THEREOF April 25, 56		NAME OF CEMETERY OR CREMATORY Woodmere		LOCATION (City, town, or county) (State) Detroit, Michigan	
24. REC'D BY REGISTRAR DATE April 24, 1956		REGISTRAR'S SIGNATURE L. J. Sealba		25. FUNERAL DIRECTOR'S SIGNATURE James H. Kirkley Address Hopping and Kirkley, Glen Burnie, Md.			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

3638
CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME - LAST, FIRST, MIDDLE

2. SEX - Male Female

3. AGE - In Years Months Days

4. DATE OF BIRTH - Month Day Year

5. PLACE OF BIRTH - State County City or Town

6. OCCUPATION

7. CAUSE OF DEATH - Immediate

8. CAUSE OF DEATH - Underlying

9. MANNER OF DEATH - Natural Accidental Suicidal

10. PLACE OF DEATH - Home Hospital Other

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. DATE OF DEATH - Month Day Year

16. TIME OF DEATH - Hour Minute

17. PLACE OF DEATH - Street No. City or Town State

18. SIGNATURE OF REGISTRAR

19. DATE OF REGISTRATION - Month Day Year

20. TIME OF REGISTRATION - Hour Minute

21. PLACE OF REGISTRATION - Street No. City or Town State

22. SIGNATURE OF REGISTRAR

23. DATE OF REGISTRATION - Month Day Year

24. TIME OF REGISTRATION - Hour Minute

25. PLACE OF REGISTRATION - Street No. City or Town State

26. SIGNATURE OF REGISTRAR

27. DATE OF REGISTRATION - Month Day Year

28. TIME OF REGISTRATION - Hour Minute

29. PLACE OF REGISTRATION - Street No. City or Town State

30. SIGNATURE OF REGISTRAR

31. DATE OF REGISTRATION - Month Day Year

32. TIME OF REGISTRATION - Hour Minute

33. PLACE OF REGISTRATION - Street No. City or Town State

34. SIGNATURE OF REGISTRAR

BUREAU V. R.

APR 26 1956

RECEIVED

3639

CERTIFICATE OF DEATH

03604 20

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAND BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodland Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>-</u> Last <u>SANSONE</u>		4. DATE OF DEATH Month <u>April</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1870</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>"UNK"</u>		14. MOTHER'S MAIDEN NAME <u>Johanna Youngquist</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Joseph Sansone</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic cardiovascular disease c</u> DUE TO <u>hypertension</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 1945</u> , to <u>April 22, 1956</u> , that I last saw the deceased alive on <u>April 21, 1956</u> , and that death occurred at <u>10:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D.		S. Borssuck, M.D. <u>4/23/56</u>	
PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u> <u>Amos Garrett Blvd., Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-25-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>John M. Taylor & Sons</u>		24b. REGISTRAR'S SIGNATURE <u>John M. Taylor & Sons</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3578

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General</i>		d. STREET ADDRESS <i>1010 West</i>	
3. NAME OF DECEASED (Type or print) First <i>Blanche</i> Middle <i>C.</i> Last <i>Scible</i>		4. DATE OF DEATH Month <i>4</i> Day <i>18</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 3^d 1886</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryd Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John E. Collison</i>		14. MOTHER'S MAIDEN NAME <i>Charlesanna Corkran</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Richard P. Scible</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial damage</i> <i>443 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arterosclerotic cardiovascular disease</i> DUE TO (c) <i>hypertension</i>			INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>hyperthyroidism</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>3-9</i> , 1956, to <i>4-18</i> , 1956, that I last saw the deceased alive on <i>4-17</i> , 1956, and that death occurred at <i>7:00 A.</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>45 Franklin St. Annapolis</i> DATE SIGNED <i>4-19-56</i>			
ACTUAL SIGNATURE <i>Edith Rodler M.D.</i>		M.D. <i>45 Franklin St. Annapolis</i>	
PHYSICIAN'S NAME (Type) <i>EDITH RODLER M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>4-21-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Nilecrest Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>DATE 4-23-1956</i>	24b. REGISTRAR'S SIGNATURE <i>J. J. Daniel</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3572

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		DATE OF DEATH	
PLACE OF DEATH		MANNER OF DEATH	
OCCUPATION		CAUSE OF DEATH	
EDUCATION		DISEASE OR INJURY	
RELIGION		TREATMENT	
MARITAL STATUS		HISTORY	
BIRTH DATE		BIRTH PLACE	
BIRTH TIME		BIRTH WEIGHT	
BIRTH LENGTH		BIRTH HEIGHT	
BIRTH HEAD CIRCUMFERENCE		BIRTH SKIN COLOR	
BIRTH HAIR COLOR		BIRTH EYE COLOR	
BIRTH BUILD		BIRTH DISEASES	
BIRTH INFECTIONS		BIRTH OPERATIONS	
BIRTH VACCINATIONS		BIRTH MEDICATIONS	
BIRTH ALLERGIES		BIRTH TRAUMAS	
BIRTH OTHER		BIRTH COMMENTS	
DEATH DATE		DEATH TIME	
DEATH PLACE		DEATH MANNER	
DEATH CAUSE		DEATH DISEASE	
DEATH INJURY		DEATH TREATMENT	
DEATH HISTORY		DEATH MEDICATIONS	
DEATH TRAUMAS		DEATH ALLERGIES	
DEATH OTHER		DEATH COMMENTS	

BUREAU V. S.

APR 24 1956

RECEIVED

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3640
CERTIFICATE OF DEATH

03606-18
W.C.

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 53 Spa Road	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Queen		4. DATE OF DEATH Month 4 Day 4 Year 19 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/46
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY — —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ira Queen		14. MOTHER'S MAIDEN NAME Annie Queen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records, Crownsville State		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Degeneration DUE TO (c) AHCVD		INTERVAL BETWEEN ONSET AND DEATH 2 days Known for 4 months "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Psychosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — — — — —	
20c. TIME OF INJURY Hour — o. n. — p. m. — Month, — Day, 19 Year		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — —		20f. (City or town) (County) (State) — — — — —	
21. I certify that I attended the deceased from 2/27 , 19 56 , to 4/4 , 19 56 , that I last saw the deceased alive on 4/3 , 19 56 , and that death occurred at 1 p. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Heard Reissmann M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Crownsville, Md. 4/4/56	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-8-56	
22c. NAME OF CEMETERY OR CREMATORY Fowler		22d. LOCATION (City, town, or county) (State) Best, State, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, II - Annapolis, Md.		24a. REC'D BY REGISTRAR DATE APR 9 1956	
24b. REGISTRAR'S SIGNATURE W. M. Joyce			

10

100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3641

CERTIFICATE OF DEATH

03607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Owen</u> Middle <u>R.</u> Last <u>Scott</u>				4. DATE OF DEATH Month <u>4</u> Day <u>14th</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-5-28</u>	
9. AGE (In years last birthday) <u>27</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cystrman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Shadyside, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John Scott</u>			
14. MOTHER'S MAIDEN NAME <u>Marjorie Matthews</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Marjorie Thompson - Shadyside, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> <u>825X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>multiple contusions + lacerations</u> DUE TO (c) <u>(ant accident)-</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>Auto accident</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>4-14 1956</u> p. m. <u>3</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Road</u>		20f. (City or town) (County) (State) <u>Shadyside A.A.C. Md.</u>	
21. I certify that I attended the deceased from <u>note 19</u> to <u>death</u> , 19 <u>1956</u> , that I last saw the deceased alive on <u>not at all</u> 19 <u>1956</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emile A. Wilson</u>				ADDRESS (Street, city or town, state) <u>Sottum, Md</u>			
PHYSICIAN'S NAME (Type) <u>acting corner.</u>				DATE SIGNED <u>4-14-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Matthews</u>		22d. LOCATION (City, town, or county) (State) <u>Shadyside Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr - Annapolis, Md</u>				24a. REC'D BY REGISTRAR <u>1771956</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Shadyside, Md</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10 CERTIFICATE OF DEATH

1041

NAME OF DECEASED		MAYNARD	
AGE		40	
SEX		M	
RACE		W	
DATE OF BIRTH		JAN 15 1901	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
OCCUPATION		LABORER	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
DATE OF DEATH		APR 17 1956	
PLACE OF DEATH		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		J. H. [illegible]	
SIGNATURE OF REGISTRAR		[illegible]	
SIGNATURE OF WITNESS		[illegible]	
SIGNATURE OF DECEASED		[illegible]	

BUREAU V. 8

APR 17 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03608	
Item 18: Film G195 4-20-56 ems										Reg. Dist. No.	
3642 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hill Beach</u>					c. LENGTH OF STAY IN 1b <u>7 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hill Beach</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Valley Road</u>					d. STREET ADDRESS <u>Valley Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BRONISLAUS JOHN SZCZEPKOWSKI</u>					4. DATE OF DEATH Month Day Year <u>April 1, 1956</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 6, 1902</u>		9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Industrial Chem.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Szczepkowski</u>					14. MOTHER'S MAIDEN NAME <u>Lena Budna</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>					16. SOCIAL SECURITY NO. <u>413-01-9535</u>		17. INFORMANT <u>Mrs. John Szczepkowski</u>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarction and myocardial</u> <u>420.0</u> DUE TO: <u>infarction due to arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with thrombosis of veins in right leg complicating</u> DUE TO: <u>cerebral arteriosclerosis</u> (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>R. S. Fisher</u>					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					<u>4/3/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>4/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>			22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Home</u>					ADDRESS <u>130 E. Fort Ave</u>		24a. REC'D BY REGISTRAR <u>APR 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. DeRella</u>		

APR 16 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3643

CERTIFICATE OF DEATH

03609

Reg. Dist. No. 23 -

Grove Cleveland Shipley.

1. PLACE OF DEATH Linthicum Heights		2. USUAL RESIDENCE (HOME) OF DECEASED Linthicum Hts.	
COUNTY Anne Arundel Co	MARYLAND	STATE Linthicum Hts.	COUNTY Q. Q. Co. Md
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Linthicum Heights	LENGTH OF STAY (in this place) all his life	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Linthicum Hts.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Linthicum Heights. Md.		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Grove Cleveland Shipley</i>		4. DATE OF DEATH (Month) <i>April</i> (Day) <i>26</i> (Year) <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 10, 1884</i>
9. AGE last birthday <i>71</i> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Builder</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building House</i>	
11. BIRTHPLACE (State or foreign country) <i>Anne Arundel Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U of Md</i>	
13. FATHER'S NAME <i>Richard Luther Shipley</i>		14. MOTHER'S MAIDEN NAME <i>Anna S. Linthicum</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>520-40-3205</i>	
17. INFORMANT & ADDRESS <i>Mrs. - J. C. Shipley.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420-1 IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>			<i>48 hours</i>
DUE TO ANTECEDENT CAUSE(S) (B) <i>Coronary Thrombosis</i>			<i>2 years</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>no</i>			
19a. DATE OF OPERATION <i>None</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 25, 1956</i> , to <i>April 26, 1956</i> , that I last saw the deceased alive on <i>April 26, 1956</i> , and that death occurred at <i>4:20 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>James S. Billingsley M.D.</i>		ADDRESS (Street, city, town, state) <i>108 Central Ave. Ellen Burns Md April 26, 1956</i>	
DATE THEREOF <i>4/30/56</i>		LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. BURIAL, CREMATION, OR OTHER DISPOSAL <i>Funeral Home</i>		24. REC'D BY REGISTRAR <i>Dr. Caldwell Woodruff</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Dickerson</i>		ADDRESS <i>4017 N. ... Md</i>	

APR 27 1956

3043 CERTIFICATE OF DEATH

1. USUAL RESIDENCE (HOUSE OR ROOMING PLACE)

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. MARITAL STATUS

11. COLOR

12. BIRTH DATE

13. BIRTH PLACE

14. BIRTH TIME

15. BIRTH WEIGHT

16. BIRTH LENGTH

17. BIRTH HEAD CIRCUMFERENCE

18. BIRTH SKIN COLOR

19. BIRTH HAIR COLOR

20. BIRTH EYE COLOR

21. BIRTH NOSE COLOR

22. BIRTH MOUTH COLOR

23. BIRTH TEETH COLOR

24. BIRTH FINGER COLOR

25. BIRTH TOE COLOR

26. BIRTH HEEL COLOR

27. BIRTH PALM COLOR

28. BIRTH SOLE COLOR

29. BIRTH HEEL COLOR

30. BIRTH SOLE COLOR

31. BIRTH HEEL COLOR

32. BIRTH SOLE COLOR

33. BIRTH HEEL COLOR

34. BIRTH SOLE COLOR

35. BIRTH HEEL COLOR

36. BIRTH SOLE COLOR

37. BIRTH HEEL COLOR

38. BIRTH SOLE COLOR

39. BIRTH HEEL COLOR

40. BIRTH SOLE COLOR

BUREAU V. S.

MAY 1 1955

RECEIVED

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, those executing the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
3644 MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
Reg. Dist. No. 03610														
1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davidsonville</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Davidsonville</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Route 214</i>					d. STREET ADDRESS									
3. NAME OF DECEASED (Type or print) <i>WILLIAM V. SIMMONS</i>					4. DATE OF DEATH Month <i>APRIL</i> Day <i>18</i> Year <i>1956</i>									
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug. 10, 1899</i>		9. AGE (In years last birthday) <i>56</i> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LAWYER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>LAW</i>		10. BIRTHPLACE (State or foreign country) <i>MISSISSIPPI</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>							
13. FATHER'S NAME <i>William T. Simmons</i>					14. MOTHER'S MAIDEN NAME <i>Nora Jane Smith</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> <input checked="" type="checkbox"/> <i>World War I</i>					16. SOCIAL SECURITY NO.					17. INFORMANT <i>Sally W. Simmons</i> Address <i>(2)</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun shot wound. Skull</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Gun shot wound</i>									
20c. TIME OF INJURY Month, Day, Year <i>April 3/18 1956</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Highway</i>		20f. (City or town) <i>FAIRFAX</i>		(County) <i>MD</i>		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>E. Linhardt</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <i>4/18/56</i>				
EXAMINER'S NAME (Type) <i>E. Linhardt</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			22b. DATE THEREOF <i>4-20-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>POHICK CHURCH CEM.</i>			22d. LOCATION (City, town, or county) <i>FAIRFAX Co. VIRGINIA</i>			(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>					ADDRESS <i>Sons Annapolis Md</i>			24a. REC'D BY REGISTRAR DATE <i>4/19/1956</i>		24b. REGISTRAR'S SIGNATURE <i>Edward Collins</i>				

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12.30

Aut.

8331

BUREAU V. S.

APR 23 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3645

CERTIFICATE OF DEATH

03611

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>California</u>		COUNTY <u>Hollywood</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort George G. Meade</u>		<u>1 Year</u>		TOWN <u>Hollywood</u>		<u>43 x .3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>1119 N. Ginesee</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>GEORGE</u>		(Middle) <u>SAMUEL</u>		(Last) <u>SINASOHN</u>		(Month) (Day) (Year) <u>April 3 19 56</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>April 3, 1956</u>	<u>38</u> yrs.	Months	Days	Hours Min. <u>1 54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henri Lathal Sinasohn</u>				<u>Beatrice Joffe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mother, 1723 C. Forest St. Ft. G.G. Meade, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>1 hr 54 min</u>	
IMMEDIATE CAUSE (A) <u>Prematurity</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Placental separation of mother</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>3 April</u> , 19 <u>56</u> , to <u>3 April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 April</u> , 19 <u>56</u> , and that death occurred at <u>10:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>ROBERT KURTH, CAPT, MC.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Robert Kurth</u>				<u>Fort George G. Meade, Md.</u>		<u>3 April 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5 April 56</u>		<u>Oheb Shalom Cem.</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>W.L. Saylor, 1st Lt, MSC</u>		<u>W.L. Saylor</u>		<u>Jack Lewis Funeral Home</u>		<u>2100 Eutaw Place Baltimore, Md.</u>	
DATE <u>4 April 56</u>							

205030/260

3579

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>43 A.A. GENERAL Hospt.</u>				d. STREET ADDRESS <u>165 Conduit St.</u>			
3. NAME OF DECEASED (Type or print) First <u>NICHOLAS</u> Middle <u>K.</u> Last <u>STARBLINGS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/6/1881</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ALBERT K. Starblings</u>				14. MOTHER'S MAIDEN NAME <u>ELLA Nutwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>214-05-0488</u>			
17. INFORMANT <u>Mrs. Rodgers Shaw</u>				Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>4/14</u> , 19 <u>56</u> , to <u>4/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>56</u> , and that death occurred at <u>12</u> <u>PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>4/15/56</u>							
ACTUAL SIGNATURE <u>John C. Hederman</u>				PHYSICIAN'S NAME (Type) <u>JOHN HEDERMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. ANNE'S</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lyle + Sons</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>4-16-1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03613		
Item 18 Film G15 120-56 ams										3646		
CERTIFICATE OF DEATH										Reg. Dist. No. 28		
1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville					c. LENGTH OF STAY IN 1b 10 mos. 24 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3701.4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital					d. STREET ADDRESS 122 5 E. Monument Street					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Guy Middle Nathaniel Last Stewart			4. DATE OF DEATH Month 4 Day 5 Year 19 56									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/22/97		9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 5 Hours 19 Min. 56		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME George W. Stewart					14. MOTHER'S MAIDEN NAME Jennie Stewart							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AHCVD - Arteriosclerotic Hypertensive Cardiovascular disease DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 4 weeks Known for 3 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Psychosis, Aortic Aneurysm and Hemiplegia												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 56				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 5/12 , 19 55 , to 4/5 , 19 56 , that I last saw the deceased alive on 4/4 , 19 56 , and that death occurred at 6:30 a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 4/5/56 ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann												
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 4/9/56		22c. NAME OF CEMETERY OR CREMATORY Baltimore Natl. Cem.				22d. LOCATION (City, town, or county) (State) Baltimore Md.				
23. FUNERAL DIRECTOR'S SIGNATURE William J. Phillips 508 N. Monroe						24a. REC'D BY REGISTRAR DATE APR 9 1956		24b. REGISTRAR'S SIGNATURE R. M. Joyce				

MEDICAL CERTIFICATION

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RECEIVED

APR 10 1956

3580

CERTIFICATE OF DEATH

03614

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Ala.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Ala.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>88 Market St.</u>				d. STREET ADDRESS <u>88 Market</u>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>R.</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 25-1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Pollitt</u>				14. MOTHER'S MAIDEN NAME <u>Ester Sherett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Chde J. Miles</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153X Intestinal Distention</u> DUE TO <u>Carcinoma of Cecum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, Heart Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3 April</u> , 19 <u>56</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>4 Southgate Ave</u> DATE SIGNED <u>4/3/56</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK M.D.</u>				<u>Annapolis md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-7-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eglinton Cent.</u>		22d. LOCATION (City, town, or county) (State) <u>Clarkston N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Leonard</u> ADDRESS <u>2880 Federal Campus N.Y.</u>				24a. REC'D BY REGISTRAR <u>4-4-1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

BUREAU V. S.

APR 5 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03615

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <u>A.A. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AAPO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		c. LENGTH OF STAY IN lb <u>1 hr</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton -</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL General</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Randy</u> Middle <u>Thompson</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>April</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 10/56</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>2</u>		12. CITIZEN OF WHAT COUNTRY? <u>Washington D.C.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Owen Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Clarice Blunt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Clarice Blunt Churchton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 day 5</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>April/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>4/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tranquilis</u>		22d. LOCATION (City, town, or county) (State) <u>Churchton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin G. G. G. G. G.</u>				24a. REC'D BY REGISTRAR DATE <u>4-21-1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. J. J. J.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Form with multiple sections for medical history, cause of death, and examiner information. Includes checkboxes for conditions like "HEART DISEASE", "CANCER", etc.

BUREAU V. 3

APR 24 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03616

3647

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 15yrs.9mos.20days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				21-03-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS North Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Louise Middle Turner Last Turner				4. DATE OF DEATH Month 4 Day 29 Year 56			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given	9. AGE (In years last birthday) 76? yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS. Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Selling Papers				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Robert Turner				14. MOTHER'S MAIDEN NAME Susan Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. Unk.			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular Dis. DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 days 16 years 16 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Double mid-thigh amputation							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 51 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crownsville, Md.				(County) (State)			
21. I certify that I attended the deceased from 2/1 , 19 56 , to 4/29 , 19 56 , that I last saw the deceased alive on 4/27 , 19 56 , and that death occurred at 4:45 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissmann				ADDRESS (Street, city or town, state) Crownsville, Md.			
DATE SIGNED 4/30/56							
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/2/56		22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital		22d. LOCATION (City, town, or county) (State) Crownsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Turner				ADDRESS Crownsville, Md.		24a. REC'D BY REGISTRAR DATE 5-3-56	
				24b. REGISTRAR'S SIGNATURE K. M. Jones			

1994, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 26

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BUREAU V. S.

355 9 MAY

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3582

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. General Hospt.</u>		d. STREET ADDRESS <u>109 Roosevelt Court</u>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>WALTERS</u> Last <u>WALTERS</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>16</u> - Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct-14-1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salesman (Auto)</u>	9. AGE (In years last birthday) <u>57</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Newark N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Waldemar Walters</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Vignes E. Walters</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary Edema &</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>360X</u> (b) <u>Coronary Thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes M.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>30 min.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/4/56</u> , 19 <u>56</u> , to <u>4/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/16</u> , 19 <u>56</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>4/17/56</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		<u>Annapolis, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr-19-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	24a. REC'D BY REGISTRAR DATE <u>4/19/1956</u>
		24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3222

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		ARMY SERVICE		MARINE SERVICE		NAVY RESERVE		AIR FORCE RESERVE		ARMY RESERVE		MARINE RESERVE		NAVY RETIRED	
CAUSE OF DEATH		MANNER OF DEATH		IMMEDIATE CAUSE		INTERMEDIATE CAUSE		UNDERLYING CAUSE		PREEXISTING DISEASE		ACUTE DISEASE		CHRONIC DISEASE		INFECTIOUS DISEASE		TOXIC DISEASE		TRAUMATIC DISEASE		CONGENITAL DISEASE		ACQUIRED DISEASE		UNKNOWN DISEASE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF ANATOMIST		NAME OF HISTOLOGIST		NAME OF RADIOLOGIST		NAME OF CLINICAL PATHOLOGIST		NAME OF LABORATORY		NAME OF INSTRUMENT		NAME OF SUPPLY		NAME OF EQUIPMENT		NAME OF MATERIAL	

BUREAU V. S.

APR 23 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03618

3583 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 117 Grandville Ave.				STREET ADDRESS (If rural give location) 117 Grandville Ave			
3. NAME OF DECEASED (Type or Print) (First) DAVID (Middle) J (Last) WIGLEY				4. DATE OF DEATH (Month) April 23, (Day) 19 (Year) 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 1, 1882	9. AGE last birthday 73 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Gambrills		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME David John Wigley				14. MOTHER'S MAIDEN NAME Alice Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mrs Aurelia May Wigley-Wife- same as # 2			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X IMMEDIATE CAUSE (A) gen. carcinomatosis						6 mos.	
ANTECEDENT CAUSE(S) DUE TO (B) Ca of stomach						18 mos.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION Sept. 55		19b. MAJOR FINDINGS OF OPERATION Ca of stomach c metastasis				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 9, 1955, to Apr. 23, 1956, that I last saw the deceased alive on Apr. 23, 1956, and that death occurred at 2:35P, from the causes and on the date stated above.							
SIGNATURE <i>S. B. Bunnick</i>				ADDRESS (Street, city, town, state) M. D. Amos Garrett Blvd., Annapolis, Md.		DATE SIGNED 4/24/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 25, 56		NAME OF CEMETERY OR CREMATORY Baldwin Memorial Cemetery		LOCATION (City, town, or county) Millersville, Maryland	
24. REC'D BY REGISTRAR <i>J. J. O'Donnell</i>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <i>Ben J. [Signature]</i>		ADDRESS HOPPING FUNERAL HOME ANNAPOLIS, MD.	
DATE 4-25-56							

2-2-2

RECEIVED

3648

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>DC Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Laurel - Rural</u>				OR TOWN <u>// Rural // - Laurel, MD.</u> 47X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Children's Center</u>				STREET ADDRESS (If rural give location) <u>Washington</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>James L. Lee Williams</u>				<u>April 23 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Single</u>	<u>11-19-52</u>	<u>3</u> yrs.	<u>5</u> Months	<u></u> Days	<u></u> Hours <u></u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Child</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>	
13. FATHER'S NAME: <u>Charlie Williams</u>				14. MOTHER'S MAIDEN NAME: <u>Edna Mae Glostex</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Records of Children's Center</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Status Epilepticus</u>						<u>14 hrs.</u>	
ANTECEDENT CAUSE (S) <u>Cerebral Spastic Paraplegia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Mental retardation</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/22</u> , 1956, to <u>4/23/56</u> 19..., that I last saw the deceased alive on <u>4/23/</u> , 19 <u>56</u> , and that death occurred at <u>2:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Lawrence T. Tatum</u>				ADDRESS <u>Laurel, Md.</u> DATE SIGNED <u>4/23/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-24-56</u>		<u>Washington DC</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-23-56</u>		<u>Phara Howard</u>		<u>Bacons Funeral Home, Washington, D. C.</u>			

MARGIN RESERVED FOR BINDING

BUREAU V. B.

MAY 2 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03620

3584 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>				TOWN <i>Annapolis - Rural</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>A. A. General Hosp.</i>				STREET ADDRESS (If rural give location) <i>Rt. 2 Box 149 - Arnold, Md</i>			
3. NAME OF DECEASED (Type or Print) <i>Phinizz Williams</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>4 27 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3-7-1901</i>	9. AGE last birthday <i>55</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Restaurant Operator Self-Employed</i>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Edgefield, S.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. a.</i>	
13. FATHER'S NAME <i>Andrew Williams</i>				14. MOTHER'S MAIDEN NAME <i>Pela Smith</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO. <i>259-14-8915</i>		17. INFORMANT & ADDRESS <i>Rev. Mrs. Williams - Arnold, Md</i>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis & hypertension</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-26</i> , <i>56</i> , to <i>4-27</i> , <i>56</i> , that I last saw the deceased alive on <i>4-27-56</i> , 19 <i>56</i> , and that death occurred at <i>7 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>P. J. Kelley</i>				ADDRESS (Street, city, town, state) <i>6 L Cothran</i>			
DATE <i>5/7/1956</i>				DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>5-2-56</i>		NAME OF CEMETERY OR CREMATORY <i>Hazel Grove</i>		LOCATION (City, town, or county) (State) <i>Beech Island, S.C.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>J. O. Daniel</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr.</i>		ADDRESS <i>Annapolis, Md.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

8 MAY 1956

RECEIVED

Ans. 10

03621

MEDICAL CERTIFICATION

2

09-15 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

APR 30 1956

RECEIVED